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ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

WINNIPEG

MAN.

VOLUME NUMBER:

14

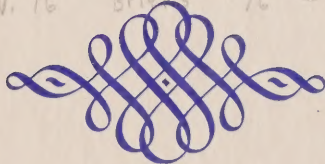
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COMMISSION COUNCIL:

MR. E. H. HALL, C.M.

MEDICAL CONSULTANT:

DR. PIERRE BÉGIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BÉGIN

SECRETARY:

Mrs. E. LAFFRANCE

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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearing
held in Winnipeg, Manitoba,
17th day of January, 1962.

COMMISSION MEMBERS:

CHIEF JUSTICE EMMETT M. HALL -- Chairman
MISS ALICE GIRARD, R.N.
DR. DAVID M. BALTZAN
PROF. O.J. FIRESTONE
MR. M. WALLACE McCUTCHEON, Q.C.
DR. C.L. STRACHAN
DR. ARTHUR F. VAN WART

COMMISSION COUNSEL:

MR. R.N. HALL, Q.C.

MEDICAL CONSULTANT:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

SECRETARY:

MAJ. N. LAFRANCE

Proceedings of the hearing
held in Washington, D.C.,
10th day of January, 1932.

DR. C. E. STAGGAL

DR. C. E. STAGGAL

DR. C. E. STAGGAL

DR. C. E. STAGGAL

DR. C. E. STAGGAL



Winnipeg, Manitoba,
Wednesday, 17th
January, 1962.

--- On commencing at 9 a.m.

SUBMISSION OF THE COLLEGE OF PHYSICIANS AND
SURGEONS OF MANITOBA

Appearances: Dr. C.H.A. Walton
Dr. A.R. Birt
Dr. M.T. Macfarland

THE CHAIRMAN: This submission will be
Exhibit No. 58.

--- EXHIBIT NO. 58: Submission of The College of
Physicians and Surgeons of Manitoba.

THE CHAIRMAN: Dr. Macfarland, who is
speaking for The College of Physicians and Surgeons of
Manitoba?

DR. MACFARLAND: Mr. Chairman, may I intro-
duce Dr. Walton and Dr. Birt. Unfortunately Dr. Hamlin,
the President of the College, is unable to attend. Dr.
Walton will speak sir.

THE CHAIRMAN: Perhaps before we start,
Dr. Walton, with your permission, as you will observe we
are somewhat behind in our agenda. That is a matter of
inconvenience, I know, to a number. We are going to carry
on though, and we may pick up a little ground today. I
think we will carry on with the list as given out. The
next will be the Faculty of Dentistry, the Manitoba Dental
Association, the Manitoba Farmers' Union, and the Society
for Crippled Children and Adults of Manitoba, so that we
will just go in that order from now on.

January, 1962.

COMMITTEE OF PHYSICIANS AND

PHYSICIAN OF THE COLLEGE

Association, Dr. C. L. A. Watson

THE QUALITY OF THE SUBMISSION WILL BE

EXAMINED, 1962

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3 DR. WALTON: I have been asked by Dr. Birt
4 and Dr. Macfarland to present a short brief from the
5 College of Physicians and Surgeons.

6 The Council of the College of Physicians and
7 Surgeons of Manitoba welcomes the opportunity of presenting
8 this short Brief to the Royal Commission on Health
9 Services, and begs to offer to the Commission any assis-
10 tance within its power.

11 The College of Physicians and Surgeons was
12 created by the Manitoba Medical Act, February 28, 1877,
13 being preceded by the Provincial Medical Board of Manitoba
14 created by Statute of the first Legislature of Manitoba
15 May 3, 1871. The College has continued under the Medical
16 Act to be the licensing and disciplinary authority of the
17 medical profession in Manitoba. Only those registered by
18 the College under the Medical Act are entitled to practise
19 medicine, surgery, and midwifery in this province. The
20 College now operates under the authority of Chapter 158
21 of the Revised Statutes of Manitoba, 1954. (Appendix 1)

22 Every person registered under the Act is
23 a member of the College. The College is governed by a
24 Council determined by formal elections among the medical
25 practitioners registered in the province. In addition
26 there are two representatives of the Faculty of Medicine
27 of the University on the Council. The Council controls
28 and administers the College and makes the necessary by-
29 laws and regulations under the Act. (Appendix 2)

30 The Council is concerned with the qualifica-
tions of those applying for registration and with matters
of discipline. It has the responsibility to ensure that

MR. WATSON: I have been asked by Dr. Birch

and Dr. Macdonald to propose a report on the

status of the medical profession in Manitoba.

The Council of the College of Physicians and

Surgeons of Manitoba welcomes the opportunity of presenting

this report to the Royal Commission on Health

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The Council is concerned with the professional

status of those applying for registration and with matters

of discipline. It has the responsibility to ensure that



1
2
3 practitioners of medicine are competent and to maintain
4 the highest standards of medical practice and education.
5 The Council has the duty of assessing Specialist qualifica-
6 tions and it maintains a Specialist Register. In doing
7 this, it maintains a close liaison with the University
8 of Manitoba, the teaching hospitals, the Medical Council
9 of Canada, and the Royal College of Physicians and
10 Surgeons of Canada. The Council also has the power to
11 initiate formal inquiry into the practice of its members
12 as well as the duty of acting on all complaints from any
13 source. These powers are exercised fully in the general
14 interests of the public, and may result in suspension of
15 the member or erasure of his name from the Register. The
16 judgment of Council is subject to appeal to the Court of
Queen's Bench.

17 The College of Physicians and Surgeons is
18 to be distinguished in origin and function from the
19 Manitoba Medical Association. The latter is a voluntary
20 association and generally serves a very different function.
21 The College of Physicians and Surgeons is primarily
22 concerned with the education and qualifications of medical
23 practitioners and with discipline. It is not directly
24 concerned with medical economics except insofar as it must
25 exercise its powers of inquiry and discipline in respect
26 of complaints regarding fees charged for services and
27 other professional matters. The Council takes pride in
28 the standards of practice which it has been able to main-
29 tain in Manitoba. It also co-operates with other licen-
30 sing authorities in Canada in the maintenance of similar
high standards.

maintain the highest standards of medical practice and education. The Council has the duty of assessing specialist qualifications and maintaining a Specialist Register. In doing this, it maintains a close liaison with the University of Manitoba, the teaching hospitals, the Medical Council of Canada, and the Royal College of Physicians and Surgeons of Canada. The Council also has the power to initiate formal inquiry into the practice of its members as well as the duty of acting on all complaints from any source. These powers are exercised fully in the general interests of the public, and may result in suspension of the member or removal of his name from the Register. The judgment of Council is subject to appeal to the Court of Queen's Bench.

The College of Physicians and Surgeons is to be distinguished in origin and function from the Manitoba Medical Association. The latter is a voluntary association and generally serves a very different function. The College of Physicians and Surgeons is primarily concerned with the education and qualifications of medical practitioners and with discipline. It is not directly concerned with medical economics except insofar as it may exercise its power of inquiry and discipline in respect of complaints regarding fees charged for services and other professional matters. The Council takes pride in the standards of practice which it has been able to maintain in Manitoba. It also co-operates with other licensing authorities in Canada in the maintenance of similar high standards.



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4 In recent years, the Council of the
5 College has had a particularly demanding role in assessing
6 the qualifications of physicians who have migrated to
7 Canada and who did not possess a Canadian qualification.
8 The Council has the duty of protecting the public by ensu-
9 ring medical competence and the moral duty of assisting
10 the immigrant physician, often a refugee, to achieve
11 qualification. In the past decade the Council has care-
12 fully assessed over a thousand applications from foreign
13 doctors. The rapid post-war growth of the province and
14 the increased demand for medical attention required more
15 medical practitioners than were available from the Univer-
16 sity of Manitoba and other Canadian medical schools. In
17 the decade 1951-60, more than 50% of the newly registered
18 practitioners in Manitoba were from the United Kingdom
19 and foreign medical schools (460 of 902). Not all regis-
20 trants practise in the province, but the results of
21 medical immigration are that 257 of 1,113 registered
22 practitioners in Manitoba in 1960 originated outside
23 Canada.

24 The existing facilities for providing
25 personal health services depend primarily on the number
26 of available qualified and registered medical practitioners.
27 It has been shown in the Canadian Medical Association
28 Manpower Study, and in the submission of this College to
29 the Provincial Commission on Medical Education (Appendix
30 3), that there is considerable concern in Manitoba and in
Canada, about the continuing supply of adequately trained
medical practitioners. There has been a steady decline
in the number of medical graduates in Manitoba. The

Canada and who did not possess a Canadian qualification.

The Council has the duty of protecting the public by ensuring medical competence and the moral duty of assisting the immigrant physician, often a refugee, to achieve qualification. In the past decade the Council has carefully assessed over a thousand applications from foreign doctors. The rapid post-war growth of the province and the increased demand for medical attention required more medical practitioners than were available from the University of Manitoba and other Canadian medical schools. In the decade 1951-60, more than 80% of the newly registered practitioners in Manitoba were from the United Kingdom and foreign medical schools (480 of 602). Not all registered practice in the province, but the results of medical immigration are that 257 of 1,113 registered practitioners in Manitoba in 1960 originated outside Canada.

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It has been shown in the Canadian Medical Association Manpower Study, and in the submission of this College to the Provincial Commission on Medical Education (Appendix 3), that there is considerable concern in Manitoba and in other provinces regarding supply of adequately trained medical practitioners.



1
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3 medical population in Manitoba has been heavily dependent
4 on immigration from the United Kingdom and from elsewhere
5 in the world. There now seems to be a slow falling off
6 in medical immigration, and it would appear that if the
7 present favourable ratio of medical practitioners to
8 population is to be maintained, more medical students must
9 be trained in Canada. The expected increase in public
10 demand for medical care under any new system that may be
11 developed, would require more practitioners or result in
12 less individual care. Obviously, we cannot count on the
13 continuing or increasing medical immigration, welcome as
14 it has been in the past.

15 The Council emphasizes the need of main-
16 taining the present high standards of medical education
17 and practice. Not only is it necessary to provide more
18 educational facilities, but it is even more urgent to
19 devise means of attracting more students of suitable
20 academic attainment to the study of medicine. The
21 lessening attraction of a medical career to university
22 students is a real but unexplained phenomenon. While the
23 general university student body has increased greatly,
24 the number of suitable applicants for medicine has
25 fallen. The Council feels that among many possible
26 factors there may be a lessening of medical prestige
27 among the public. The heavy demands on students and
28 practitioners require the added inducement of a respected
29 professional status. Professional status may be further
30 reduced by any unnecessary interference by government or
other bodies. Curiously, and perhaps understandably, as
medical services have become more useful to the community



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3 and in greater demand, the profession has come under
4 increasing criticism, not all of it constructive.

5 The Council is of the opinion that the
6 high cost of medical education may be an important factor
7 in lowering the number of applicants. This high cost is
8 made up not only of the relatively high university fees
9 but also by the long years of unpaid training during
10 which the student's contemporaries are becoming finan-
11 cially established. There are no compensating income tax
12 privileges to enable the recent graduate to recover from
13 these financial disadvantages. The expenditures made by
14 a student or his family for medical education and his lost
15 potential income during his long years of training,
16 represent a large capital investment for which no provi-
17 sion is made in income tax law. This contrasts sharply
18 with the student's observations of other fields of endea-
19 vour. The vastly increased cost in money and time of
20 specialist education accentuates this problem.

21 The Council recommends that great care be
22 given to the problem of the provision of adequate clinical
23 facilities for medical teaching. If the present methods
24 of medical care are changed so that all patients come
25 under private medical attention, the public teaching
26 services will be seriously depleted. The provision of
27 highly organized and expensive university clinics would
28 then become a necessity.

29 The distribution of medical practitioners
30 is uneven between urban and rural areas for economic,
cultural, and environmental reasons. (Appendix 3 -
Table 1C) In general, this College agrees with the

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The distribution of medical practitioners

is uneven between urban and rural areas for economic, cultural, and environmental reasons. (Appendix 3 - Table 10) In general, this College agrees with the



1
2
3 submission of the Manitoba Medical Association in this
4 matter.

5 IN SUMMARY, the Council of the College
6 believes that it is most important that the supply of
7 students and medical practitioners be maintained and
8 increased. The Council also makes the plea that all
9 matters relating to licensure of applicants for registra-
10 tion, and all disciplinary matters remain under the
11 control of the profession as at present under the Medical
12 Act. The Council should continue to be the only authority
13 empowered to receive and act on complaints relating to
the practice of medicine in the province.

14 THE CHAIRMAN: Thank you, Dr. Walton.
15 Are there any other comments that Dr. Birt or Dr. Macfar-
16 land would like to make, or that you would like to make
yourself, Dr. Walton?

17 DR. WALTON: At the moment I don't think
18 so sir.

19 DR. MACFARLAND: Mr. Chairman, from your
20 questions asked yesterday, which I deferred until this
21 morning, and I have submitted to the Secretary, and I
22 believe the members have copies, sir, of the first part
23 of the Registrar's Report of 1960, which deals more
24 fully with the topic, and that Manitoba has welcomed the
25 foreign physician. Unless it is your wish sir this
26 morning, as you are running behind time, I will not read
that in its entirety.

27 THE CHAIRMAN: If you just want to give us
28 a synopsis of what the College has done in welcoming the
29 foreign physician.
30

IV SECRETARY, the Council of the College
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4 DR. MACFARLAND: Yes sir. Specifically
5 we might refer to page 120 of the submission of the
6 Manitoba Medical Association, which was the result of a
7 joint study by a committee of the Manitoba Medical Association
8 and the College. Dr. Walton was a member of that
9 committee with Dr. Sisler, and those figures summarize,
10 sir, in the Table I, the new registration of medical
11 practitioners in Manitoba 1941-1960 by five-year periods
12 with country of training. The figures which follow on
13 Table II, page 121, show that from 1950 to 1962 it
14 decreased from 59 to 37 annual new registrations in
15 Manitoba of Canadian graduates, and an increase from 25 to
16 50 annual new registrations of foreign schools. Total
17 new registrations annually have fluctuated between 80
18 and 100 but show no trend. The attrition rate is such
19 that the total number of registered physicians has
20 increased steadily by approximately 30 per year, and the
21 physician-population ratio has changed from 1 in 1,000 in
22 1950 to 1 in 879 in 1960.

23 I think sir, that the record of Canada and
24 of Manitoba is justifiably a proud one in that respect,
25 but it shows the dependence on those who are immigrants.

26 THE CHAIRMAN: You suggest in your submission
27 that this flow may be drying up somewhat, although I
28 may have misunderstood you I thought you said that you
29 didn't discern a trend. Is there an actual falling off
30 in the number?

DR. MACFARLAND: There appears to be a
falling off, sir, in that direction.

COMMISSIONER BALTZAN: Just one thing, Dr.

DR. MACFARLAND: Yes sir. Specifically

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COMMISSIONER BALDWIN: Just one thing, Dr.



1
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3 Walton. In 1951 to 1960, more than 50% of the newly
4 registered practitioners in Manitoba were from the United
5 Kingdom and foreign schools. 460 of 902. Then later
6 on, not all registrants practise in the province, but
7 the results of medical immigration are that 257 versus
8 1,000-plus of the medical practitioners who remain. My
9 question is this: perhaps half remain in Manitoba who
10 register, I mean going by these figures?

11 DR. WALTON: I don't think so, Mr. Chairman.
12 You see, half the registrants in a decade were from
13 abroad, but of course many registrants had been practising
14 for a long time before the last decade. This modifies
15 the percentages considerably, but it is true, Mr. Chairman,
16 that many come to Manitoba to achieve registration and
17 move on to other areas. Some may stay a matter of years
18 then move, others may come just to receive registration.

19 THE CHAIRMAN: These other provinces do
20 not receive them initially?

21 DR. WALTON: Yes. I think it is important
22 to note that in the last ten years that one-quarter of
23 the present doctors do originate from abroad, outside of
24 Canada. I think this is the important point, but the
25 trend is such that this proportion will be higher as each
26 year goes by, because the older men will be dropping out
27 through the normal attrition of life.

28 COMMISSIONER BALTZAN: That has been the
29 experience in some other provinces, and other provinces
30 have not been able to say how many of these who do not
remain in that particular province remain in Canada, or
as we found so many numbers, not exact, then tend to go,

...the number of registrants in the United Kingdom and foreign schools, 430 of 902. Then later on, not all registrants practise in the province, but the results of medical immigration are that 257 versus 1,000-plus of the medical practitioners who remain. My question is this: perhaps half remain in Manitoba who register, I mean going by these figures?

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say to the United States, or return home.

DR. WALTON: Sometimes they go to other places in the Commonwealth: Malaya, Hong Kong and various places in Africa because of British registration.

COMMISSIONER BALTZAN: So that the number of the influx is not actually the number to count on. It is the number who remain and locate and practise. Thank you.

COMMISSIONER VAN WART: Does your College a year's internship in the province before you register them?

DR. WALTON: Yes, sir. Under the Medical Act of Manitoba there is an internship -- a quasi-satisfactory internship, and this is judged by the College. The College makes the decision as to whether the year's internship has been adequate and satisfactory for the purposes of the Act. Nobody is registered in Manitoba no matter what their qualifications are if they have not satisfied the College as to that.

COMMISSIONER VAN WART: Do you request all the immigrant doctors to serve one year internship in your province before you register them?

DR. WALTON: Not all. Some come to us with obviously quite adequate internship. There are many immigrant doctors from Europe who come via Great Britain where they have had good training. A few have come via the United States and they also had good training, and the information can be assessed and is adequate. If there is the slightest doubt as to the quality of the internship or as to whether they understand

say to the United States, or return home.

DR. WALTON: Sometimes they go to other places in the Commonwealth: Malaya, Hong Kong and various places in Africa because of British registration.

COMMISSIONER BARKMAN: So that the number of the influx is not actually the number to count on. It is the number who remain and locate and practise.

COMMISSIONER VAN WART: Does your College have a year's internship in the province before you register them?

DR. WALTON: Yes, sir. Under the Medical Act of Manitoba there is an internship -- a satisfactory internship, and this is judged by the College. The College makes the decision as to whether the year's internship has been adequate and satisfactory for the purposes of the Act. Nobody is registered in Manitoba no matter what their qualifications are if they have not satisfied the College as to that.

COMMISSIONER VAN WART: Do you request all the immigrant doctors to serve one year internship in your province before you register them?

DR. WALTON: Not all. Some come to us with obviously quite adequate internship. There are many immigrant doctors from Europe who come via Great Britain where they have had good training. A few have come via the United States and they also had good training, and the information can be assessed and is adequate. If there is the slightest doubt as to the quality of the internship or as to whether they understand



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3 the type of practice that occurs in this part of the
4 world, they are required to serve one year. In most
5 instances this gives the applicant the opportunity to
6 learn the language and local customs.

7 COMMISSIONER McCUTCHEON: Dr. Walton, I
8 would like to expand somewhat on the statements that are
9 contained in your Appendix 3, particularly in paragraph 5
10 on page 13 and following, on medical education. I judge
11 that what you are saying is that if everyone in Manitoba
12 were able to pay medical bills that there would have to
be a radical change in your system of teaching?

13 DR. WALTON: Yes, sir.

14 COMMISSIONER McCUTCHEON: Assuming that
15 the trend is that more and more people will be able to
16 pay their medical bills, whether by Government arrange-
17 ments or otherwise, what do you see as the requirements
for medical education?

18 DR. WALTON: I think the problem is this,
19 sir: the teaching of medicine involves the necessity of
20 the student having access to sick people under supervision.
21 As you know, sir, the average private patient is not too
22 willing, for obvious reasons, to have students working on
23 or with him. A few patients rather enjoy it, but speaking
24 broadly one has to use a good deal of persuasion and tact
25 to require a private patient to submit to the presence of
26 students, and this is particularly important, of course,
27 in female patients. It is less difficult among men, but
28 it does exist there too. In the past teaching has
29 occurred on the so-called public services, both in-patient
and out-patient, in which medically indigent people have

of practice that occurs in this part of the world, they are required to serve one year. In most instances this gives the applicant the opportunity to learn the language and local customs.

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DR. WALTON: Yes, sir.

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been admitted in very large numbers to teaching wards and teaching out-patient clinics, and these people are admitted on the condition that they permit students, both graduate and under-graduate, to attend them under supervision. This has worked very well, but the source of this material is now drying up. The more of the medically indigent who come under some other method of providing attention the less of them are available for teaching purposes. If all people, irrespective of indigency or financial status, are provided by one method or another with medical attention, then all become, in effect, private patients, and these people have the same right that any private patient has of refusing to take part in the teaching program. It seems to us, then, it was necessary to devise some other method of attracting patients to teaching clinics. There are many places in the world where there are university clinics which have set up to receive patients -- admittedly, they pay for their service, but these clinics have developed a reputation and a standing which attracts patients. In other words, sir, the teaching clinic, if it is to attract sufficient patients to teach students and post-graduate students, must be of a calibre that is as good or perhaps even a little better than the service that could be offered in private practice. It is perfectly obvious that no patient, no matter what rank of society he may come from, is going to sit on a hard bench in a crowded out-patient department for many, many hours and perhaps see a doctor but not the doctor of his choice just for the purpose of being a teaching subject. However, if he

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5 private office, and if he does so because he really wants
6 the particular type of attention that he thinks he will
7 obtain at that university clinic -- in other words, the
8 calibre of the people who are attending, the class and
9 work and reputation and so on -- then he will go there
10 because he wants that attention and he will go there
11 knowing that part of the attention includes teaching.

12 This, I think, means a revolution in the
13 provision of teaching facilities. It means the old
14 methods which did work under former circumstances are now
15 becoming more and more difficult, and unless some radical
16 change is made there will be no teaching material.

17 This has been underlined just recently in
18 Manitoba under Medicare. People on welfare can now
19 obtain medical attention privately, as you heard yesterday.
20 In my own practice I have seen a number of these Medicare
21 patients and they have refused point blank to have any-
22 thing to do with a teaching function. For example, if
23 they needed x-rays and it was my duty to send them to the
24 general hospital or the St. Boniface Hospital, most have
25 made excuses or refused to go or by some method or other
26 dodged it. Perhaps they get the help of a friend who
27 gives them private x-rays. The point is there is a great
28 reluctance on the part of people to undergo teaching
29 demonstrations except under the individual doctor that
30 they want. If I had taken this patient myself that
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8 with it if they could avoid it. If they had no alter-
native, they had to go.

9 COMMISSIONER McCUTCHEON: What is the
10 alternative? Is it a closed university teaching hospital?

11 DR. WALTON: I am sure there must be some-
12 thing equivalent to that.

13 COMMISSIONER McCUTCHEON: What is the
14 situation today in the Winnipeg General Hospital? Are
all the members of the staff university appointees?

15 DR. WALTON: All full members of the staff
16 are university appointees, but there are many people with
17 courtesy privileges at the hospital.

18 COMMISSIONER McCUTCHEON: There are more
19 courtesy privileges extended than there are, say, in
the teaching hospitals of Toronto: would you say that?

20 DR. WALTON: I am not too familiar, but
21 I believe this is true. In our hospitals the teaching
22 wards are restricted to the university appointees, but
23 other wards are open to the courtesy staff if they wish
24 to use them.

25 COMMISSIONER McCUTCHEON: Are they so-called
standard wards that are open?

26 DR. WALTON: The standard wards are in two
27 categories.

28 COMMISSIONER McCUTCHEON: It is what we
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DR. WALTON: But our wards are of two kinds; those that are open and those closed for teaching purposes; but the standard wards for teaching purposes become less numerous and the other wards are growing bigger.

COMMISSIONER McCUTCHEON: You see that trend?

DR. WALTON: Yes.

THE CHAIRMAN: There is a Commission that has been working on that subject just recently, and I understand the report is due very soon?

DR. WALTON: Yes. The Manitoba Commission on Medical Education is working on this. We felt it important to draw attention to it because it has much wider implication than just the provincial implication. If the patients are changed by the economic situation, and if we change their economic situation, then we change their motivation.

COMMISSIONER McCUTCHEON: At some point here you refer to a university teaching unit as being competitive to private practice: I may have drawn the wrong inference, but do you regard that as an objection to a university teaching unit?

DR. WALTON: No sir, this term is used perhaps improperly, but used to underline the necessity of a university clinic offering as good or better services than a private one.

COMMISSIONER McCUTCHEON: There are large hospitals in the States today, are there not, where people come from long distances because they respect or

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3 believe they will get care and attention, and they are
4 teaching material from the time they go through the door?

5 DR. WALTON: That is quite right. It
6 happens in many centres. A very well known one is the
7 Billings in Chicago. I am just reminded these hospitals
8 referred to in the United States, such as Billings, are
9 mostly post-graduate teaching. Under-graduate teaching,
10 so far as we are aware, has not been handled this way,
11 but obviously the same principles apply.

12 COMMISSIONER VAN WART: Are there any in
13 Canada, or do you see any tendency towards the establish-
14 ment of them?

15 DR. WALTON: Yes, sir. In Saskatoon there
16 is the University Hospital which is setting up in this
17 way, but the people coming from Saskatoon know this
18 better than I do; but it is the only one I know of.

19 COMMISSIONER VAN WART: Laval has one.

20 DR. WALTON: Laval, yes.

21 COMMISSIONER McCUTCHEON: Are midwives
22 licensed in this province?

23 DR. WALTON: No, sir.

24 COMMISSIONER McCUTCHEON: Why not --
25 especially when there is a shortage of physicians in the
26 rural areas?

27 DR. WALTON: I don't know that I can
28 answer that question directly. I suspect there is an
29 historical reason for this. I would suspect it may be
30 very difficult to persuade the people of the province to
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7 that use midwives: it would set up a pattern which might
8 be complex, and, as far as I know, there has been no
9 great demand, if any.

10 COMMISSIONER FIRESTONE: Dr. Walton, on
11 this question of obtaining an adequate supply of training
12 material, how has the United Kingdom resolved this
13 problem?

14 DR. WALTON: I am really not entirely sure
15 about this, but of course in the United Kingdom the
16 medical service is provided through a panel system through
17 general practitioners. If a patient has a disease which
18 needs something more than the practitioner can provide,
19 he then refers him to a hospital where the necessary
20 specialists and services can be provided. He goes to
21 that hospital and he has no place else to go unless he
22 goes to a private consultant, which he can do -- and it
23 is done on a small scale among the more well-to-do people
24 and in the larger centres -- but normally a person has to
25 go to the hospital to which he is sent because there is
26 no alternative and there is no competitive situation.
27 In Canada, unless we had precisely the same system as
28 Britain -- and this would appear to be highly unlikely --
29 a competitive situation is the thing which would make a
30 patient go one way rather than another.

31 COMMISSIONER FIRESTONE: In paragraph VII
32 on page 4 of your submission you say, "If the present
33 favourable ratio of medical practitioners to population is

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on page 4 of your submission you say, "If the present
favourable ratio of medical practitioners to population is



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3 to be maintained, more medical students must be trained".
4 I presume the problem will get even more acute if as a
5 result of greater demand for medical services and as a
6 result of a prepaid medical scheme you will require that
7 the ratio of medical practitioners to total population be
8 increased; therefore, your problem of the future seems
9 to be even greater than the problem of the present?

10 DR. WALTON: Yes, sir.

11 COMMISSIONER FIRESTONE: If this is the
12 case, has your College of Physicians and Surgeons any
13 specific suggestion to make as to how you can achieve
14 or attract more medical students in the Province of Mani-
toba?

15 DR. WALTON: In tackling this question,
16 as we word it in our brief, we have been uncertain as to
17 all the factors involved. We believe more facilities
18 need to be created in Canada. I think we should look
19 beyond just Manitoba. Our own school is capable of
20 handling perhaps 25% more students than it does now, but
21 this is only a small part of the picture. We believe
22 there is need for more medical schools in Canada, and we
23 think there are steps being taken in that regard now.
24 As to the recruitment of medical students, this is a
25 problem we have studied a great deal, and we do not know
26 the full answer. We have submitted, though, in our
27 brief that perhaps the economics of studying medicine is
28 more important than has been previously suggested, and
29 many a young man -- when we talk to them we try to be our
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street is married and has three children and has a house with ten years off the mortgage, this is a mug's game". This is how they talk. This is the only guide we have, and that is why we make the remarks we make with regard to the methods of assisting the young students and making it attractive. We feel, as does the Manitoba Medical Association, that this could apply not only to medicine, but to post-graduate students in all fields, because it is well known in Canada as elsewhere that there is a shortage of highly trained people above the bachelor level, and surely the same principles must apply.

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COMMISSIONER FIRESTONE: You are quite right and we are very grateful to you for having extended the plea for higher education to all areas. I think the point is well made. I am wondering, having suggested that some action should be taken, whether your group has any specific proposals. We appreciate it is a very desirable objective and education should be for all but is there anything specific like scholarships, loans, education, persuasion, facilities, etc.? This Commission is trying to obtain concrete suggestions that we can consider.

DR. WALTON: The only concrete suggestion that we have made and could make at the moment, attention should be given to the tax problem. This is a common and serious complaint among the young men who are finishing their studies and trying to go ahead with future studies and I think this has merit. The alternative of scholarships and bursaries, we do not feel these are really more than a very small factor. Indeed, full advantage has not been taken of that as was referred to yesterday. It might be their design is wrong, students do not like to ask for charity nor do they like to become indentured servants which is what some of these scholarships mean. It may be a man may wish to practise medicine in North-western Manitoba but when he is told he must do it as part of his bursary then he moves away as fast as he can. That is not the answer. The question of fees is of importance but not great importance as it is nearly part of the total cost.

COMMISSIONER FIRESTONE: You are emphasizing

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right and we are very grateful to you for pointing out the point is well made. I am wondering, having suggested

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the necessity for graduate studies and graduate training and you suggested this income tax matter as one possibility. I think you also seem to think that perhaps the primary problem is getting students interested in the field of medicine in the first place. If you get them into the field, once they have graduated you may have other means of persuading them to do post-graduate work so the key problem is getting them into the field of medicine in the first place. You suggested some of the terms of the scholarships or bursaries are too tight and tough to be an inducement. What would be the alternative to this sort of system which you have now which you have suggested yourself has not worked as well as you would like to see it work? What is the alternative?

DR. WALTON: In the final analysis it is not the financial aspect that discourages the student. He has to have a strong motivation that he wants to serve people and study medicine and he has biological interests that lead him this way. Most of us in the field find it extraordinarily difficult to understand why young men are not as attracted to it as they were in the past, particularly when medicine as a science and an art has become much more interesting in recent years than it has ever been in history. It is a strange psychological phenomena that is hard to come to grips with. I might point out since the war, and perhaps right down through history, there has been a tendency perhaps in the press, perhaps in the public utterances to be highly critical of doctors - there is reference in our brief - so much so perhaps young men themselves do not think it is a great profession

and you suggested this income tax matter as one possibility.

I think you also seem to think that perhaps the primary problem is getting students interested in the field of medicine in the first place. If you get them into the field, once they have graduated you may have other means of persuading them to do post-graduate work so the key problem is getting them into the field of medicine in the first place. You suggested some of the terms of the scholarships or bursaries are too tight and tough to be an inducement. What would be the alternative to this sort of system which you have now which you have suggested yourself has not worked as well as you would like to see it work? What is the alternative?

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He has to have a strong motivation that he wants to serve people and study medicine and he has biological interests that lead him this way. Most of us in the field find it extraordinarily difficult to understand why young men are not as attracted to it as they were in the past, particularly when medicine as a science and an art has become much more interesting in recent years than it has ever been in history. It is a strange psychological phenomenon that is hard to come to grips with. I might point out since the war, and perhaps right down through history,

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3 as it was. We do not know this, it is only a suggestion.
4 A few years ago there was some discussion in the public
5 press about too many doctors being trained and there was
6 a question as to whether a new school which was then
7 opening in Saskatchewan was a good or bad thing for
8 Canada. The implication in this case was that the profes-
9 sion would become overcrowded. For a personal example,
10 my son, who was then in high school, attended an oppor-
11 tunity class at the high school and there was addressed
12 by a fairly prominent physician who was sent with the
13 University's blessing. In this case the doctor discour-
14 aged them from going into the study of medicine, and
15 tried to steer them into the sciences and anything else
16 but not medicine. My son is not now a doctor but this
just shows the psychological approach.

17 COMMISSIONER FIRESTONE: You make the
18 point the discouragement came from another doctor?

19 DR. WALTON: Yes, and I think he was
20 talking about public feeling at the time.

21 COMMISSIONER FIRESTONE: And you described
22 the cost of medical education and financial incentive and
23 I think many young students that are thinking about a
24 career in medicine probably can be satisfied that the
25 financial rewards in medicine are fairly good. Our
26 income tax statistics show the medical practitioners in
27 Canada have the highest income of any profession. I
28 think you could assure a young man that when he gets
29 proper training and does a good job he will be all right
30 in terms of financial rewards. However, the problem of
the cost of training still remains. There may be bright

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3 young students who have not the money to go through
4 medical school and the parents are not in a position to
5 provide the funds and it is therefore a problem of
6 medical education that we are primarily concerned with.
7 The question arises, what can be done to facilitate the
8 entry of bright young students who have not got the
9 resources to go through medical school? As you suggested
10 earlier there are schemes and bursaries available that
11 have not been taken up; you have empty spaces in your
12 medical school and we need more doctors. Surely there
13 must be some way of matching supply and demand through
14 some sort of system. We come to you for advice as to
15 what can be done.

16 DR. WALTON: We do not know of many
17 students of good academic standing who have been unable
18 to pursue their careers because of financial inability.
19 Now, this does not mean there are not any, it means they
20 have not come to our attention. The few we have known,
21 there have been ways and means of helping them through
22 the Alumni Association of the University and many other
23 organizations. When these cases come to our attention
24 very grave efforts are made to help them. I do not know
25 how to find this out. There may have been students who
26 have been discouraged privately and have not asked for
27 help. Surely this is a broad problem of University educa-
28 tion and I suppose it applies to all branches. I am
29 sorry that neither my colleagues or myself have any
30 specific suggestion to make in this regard.

31 COMMISSIONER FIRESTONE: Perhaps I could
32 put this specific question to you. You mentioned you had



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3 a system of provincial bursaries in the Province of
4 Manitoba and because of some of the terms attached to it
5 some students may not be interested in it because they
6 do not want to tie themselves down to practising medicine
7 in a rural area. One can understand why the Province of
8 Manitoba attaches such conditions because they may feel
9 if you provide this assistance to a student you would
10 like to have them, after they graduate, practise in
11 Manitoba and perhaps in certain parts of Manitoba. Now,
12 if we had a national scholarship system that would be
13 applicable to all students taking up the training of
14 medicine wherever they are going to reside would that not
15 overcome the difficulty you are facing now in Manitoba?

16 DR. WALTON: Yes, I believe it would help
17 a great deal.

18 COMMISSIONER FIRESTONE: In other words,
19 your College would support a national scholarship based
20 on a comprehensive basis, the medical student wanting to
21 take up medicine and practise anywhere in Canada?

22 DR. WALTON: Yes, I think that is quite
23 true, the College would undoubtedly support it.

24 COMMISSIONER FIRESTONE: Knowing that many
25 of the students trained in Manitoba would end up in
26 Ontario or British Columbia?

27 DR. WALTON: It is basic medicine that a
28 student should not be tied, he should go where his
29 inclination takes him, it is the only healthy way.

30 COMMISSIONER FIRESTONE: You are in favour
of mobility of medical people in Canada?

DR. WALTON: Very much.

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26 COMMISSIONER FERGUSON: You are in favour
27 of mobility of medical people in Canada?



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4 COMMISSIONER FIRESTONE: I will come to
5 your by-laws, rules and regulations 54 and Section No. 6
6 and I will read this paragraph:

7 "The Registration Committee shall decide
8 as to the eligibility of the applicant to
9 receive the Enabling Certificate. Should
10 the documentary evidence submitted fail
11 to satisfy the Registration Committee,
12 the applicant may be required to pass the
13 examinations of the fourth year, Faculty
14 of Medicine, University of Manitoba, or
15 the equivalent thereof, and to serve not
16 less than 12 months in a resident medical
17 capacity in an approved hospital or hospi-
18 tals".

19 Now, can you explain to us a little, and
20 you have done so in part, but perhaps in a brief way how
21 you administer this paragraph when it comes to approving
22 admission of graduates of foreign medical universities
23 or faculties?

24 DR. WALTON: In effect this paragraph has
25 not been used; to my knowledge no student, no applicant
26 has been admitted to fourth year medicine for further
27 study so that actually although this paragraph may be
28 looked upon as permissive, it has never come into use.

29 COMMISSIONER FIRESTONE: How then, in
30 fact, do you decide whether a foreign physician should
be admitted or not?

DR. WALTON: Well, sir, one learns by
experience and by other methods which schools give

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COMMISSIONER LESTER: I will come to



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4 adequate training, which schools give questionable
5 training and which schools give bad training. This is
6 knowledge not peculiar to our College. As you know the
7 Brockville Foundation has made a number of extensive
8 studies in this regard. Many of our own people here by
9 travel and education have learned a great deal about
10 particular schools and when a candidate comes to us who
11 has been educated at a particular school and if his
12 documentation is in order, if we are satisfied this
13 school is up to the standards we believe are equivalent
14 to our own then very little more is done except the candi-
15 date is asked to write the Medical Council of Canada
16 examination. He may or may not be required to take an
17 interneship. However, if the school has a standard which
18 we cannot accept for one reason or another as equivalent
19 to our own then other steps may have to be taken. For
20 instance, basic sciences may be deficient and in this
21 case the University assists us in assessing the basic
22 science equivalents. It may be a graduate has training,
23 he may have come from a school which is perhaps not of
the best but his subsequent training in other centres
has been such that we are satisfied any deficiency may
have been made up.

24 COMMISSIONER FIRESTONE: If I understand
25 you correctly, you and your associates have made for
26 practical operating purposes a list of medical schools
27 on the continent of Europe and show these schools which
28 are considered to be providing training equivalent to
29 yours. This is done in the United States. Where you
30 consider a graduate has not received proper training you



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3 require him to sit for an additional examination, is
4 that correct?

5 DR. WALTON: There is no list and
6 experience, of course, changes from year to year. If
7 I may be permitted to give an example, there were some
8 schools in mainland China that at one time were very
9 highly regarded but they are not as highly regarded now
10 chiefly because we do not know as much about them. They
11 may be as good but we do not know and so we cannot act.

12 COMMISSIONER FIRESTONE: I was making the
13 answer to my question a little easier by confining it to
14 Europe, especially Western European universities where
15 changes may not be so drastic as in China.

16 DR. WALTON: They were drastic in this
17 respect that at the end of the war many of them had very
18 adequate schools but since then over the 16 or 17 years
19 that have elapsed some of the poorer schools have become
20 good so again there has been a change upwards in that
21 respect.

22 COMMISSIONER BALTZAN: In that same regard,
23 Dr. Firestone has been speaking to you about, can you,
24 for the information of the Commission, state what is the
25 equivalent type of examination testing these exchange
26 students or foreign students coming into the States?
27 What is that called, they have a special examination?

28 DR. WALTON: I never can remember this
29 because it has five names in it. It is the E.C.F.M.G.,
30 Educational Council for Foreign Medical Graduates. The
United States have set this up as a preliminary weeding
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6 of this preliminary screening which helps us to assess
7 the possibilities of a particular candidate. If he
8 does not pass this his chances of passing anything are
9 not good. However, just because he has passed this
10 preliminary screening does not mean he will succeed in
11 qualifying here.

12 COMMISSIONER FIRESTONE: There must be a
13 dozen or more medical schools and universities on the
14 continent of Western Europe, excluding the British Isles.
15 Would you say there are a number of them that you
16 consider to provide equivalent training to the satisfaction
17 of the Manitoba Council of Physicians?

18 DR. WALTON: I think a very large number
19 of them.

20 COMMISSIONER FIRESTONE: Would it be
21 possible, perhaps, to obtain this information from you
22 at some future occasion in writing as to the universities
23 which you consider provide such equivalent training? I
24 am not trying to ask you to answer now because it may be
25 difficult.

26 DR. WALTON: It may be possible to give
27 you a list of universities but we in the past have
28 accepted it would be difficult to extend that into the ---

29 COMMISSIONER FIRESTONE: It would be ade-
30 quate to show what you have accepted. I will explain
31 how this can be helpful to us. We presume there may be
32 a different attitude towards the acceptability of degrees



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5 one province is more liberal than another or more helpful
6 than another and the only way we can compare what the
7 different practices in different provinces is if this
8 information could be made available to us in writing.

9 DR. WALTON: I would like to say that the
10 American Medical Association published such a list some
11 time ago but it discontinued the list because they were
12 unable to maintain frequent inspections because these
13 schools were changing a good deal. We have been very
14 fearful of lists for this reason because you can turn down
15 a candidate for a number of reasons, not only his school.
16 You may accept a candidate for examination and he may
17 pass and become a practitioner and a very good one and
18 a year later a candidate will come from the same school
19 as the first one who obviously has not the standard
20 expected of him. Then we have that problem because
21 obviously the man's living is involved. We have been
22 chary of this. I am sure we can provide a list of univer-
23 sities from which we have accepted candidates.

24 COMMISSIONER FIRESTONE: This will be
25 completely adequate. We are interested in the facts and
26 what you have done and it would help us in comparing
27 with other Councils in other provinces.

28 COMMISSIONER McCUTCHEON: It is implicit,
29 I take it, that even if you supplied this list, the fact
30 you accepted a graduate from a particular university
five years ago would be no guarantee that you would
accept a graduate of the same university tomorrow morning?

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DR. WALTON: That is right.

COMMISSIONER FIRESTONE: I take it, Dr. Walton, you would be judging each case on its merits?

DR. WALTON: That is right.

COMMISSIONER BALTZAN: I ask this, Dr. Walton, in order that it may help me change my own impressions, and I put the question in this way, if you are willing, or care to answer, or your associates. Is it altogether true that widespread prepaid medical services, proportionately and correspondingly increase the volume of medical work? I say this because this spread over a larger number of people includes so many more healthy individuals. Does prepaid, widespread availability of medical services proportionately or correspondingly require, say, twice as many doctors, or something of that nature?

DR. WALTON: Speaking personally, I am sure my opinion would be the same as my colleagues on the Council. The easier it is to obtain medical attention, the more it is demanded. If the financial barrier is lessened, or withdrawn, experience has taught us all along that the amount of medical attention demanded or asked for is increased. If one assumes that the present number of physicians are fully occupied, and if the demand increases, it naturally follows we will need more physicians to cope with the demand.

COMMISSIONER BALTZAN: There is on the other hand a claim on the part of the medical services, co-operatives, or insurances, that the more attractive group, the more attractive subscribers, is a group,

WALTON: That is right.

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5 more people, so that there are many more who are not
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8 insurance. By that same token, one might take it that
9 if it were spread all through your province it won't
10 necessarily mean that the load on your doctors would be
proportionately greater. Do you see my point?

11 DR. WALTON: Yes, your point sir is that
12 by having a larger number of insured people you lessen
13 the risk, but because that risk is lessened it does not
14 follow, I don't think, that the amount of attention
15 demanded would be the same. I think it would be
16 increased, because as soon as you lessen the financial
17 barrier you increase demand. If there is a scratch on
18 your automobile and it is insured you will have the
19 scratch fixed. If it is not insured you might put up
with it a while.

20 COMMISSIONER BALTZAN: I value your
21 opinion because it is helping me in my mind.

22 COMMISSIONER VAN WART: The Medical
23 Council of Canada is the sole portal of entrance, or
24 do you have your own examinations?

25 DR. WALTON: Our College does not conduct
26 examinations, except if occasion arises we may ask the
27 University to do it. Our portal of entry is through the
28 Medical Council. A registrant from Great Britain who
29 has internship and is registered under the General
30 Medical Council of Great Britain, is automatically

as against the individual, because the premiums can be less, and the premium is less because there are many more people, so that there are many more who are not going to be utilizing that service to the same extent as if only selected individuals apply for protection, or insurance. By that same token, one might take it that if it were spread all through your province it won't necessarily mean that the load on your doctors would be proportionately greater. Do you see my point?

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3 eligible for registration. In the case of those coming
4 under reciprocity, we advise them to write to the Medical
5 Council, because this gives them mobility in Canada, but
6 they are not required to under reciprocity.

7 COMMISSIONER VAN WART: Is the mortality
8 of the applicants very high in this examination?

9 DR. WALTON: The mortality, the failure
10 rate among foreign graduates is quite high. I am sorry
11 I haven't got the figures available at the moment, and I
12 believe the Medical Council of Canada will be submitting
13 these figures later, but the failure rate among British
14 candidates is relatively ---

15 COMMISSIONER VAN WART: The failure rate
16 among entrants, if it is higher than those who graduate?

17 DR. WALTON: I don't think the failure
18 rate today is as high as it was formerly, and perhaps
19 this is due to a more rigid selection of students on
20 academic attainment, but the number of graduates is
21 certainly smaller than the number of entrants.

22 COMMISSIONER VAN WART: Do you feel that
23 the failure rate, or are you offsetting that more selec-
24 tive method of accepting students is keeping down the
25 number of students entering medicine?

26 DR. WALTON: Yes, I think it is one of
27 the factors, sir. I have known of individual students
28 who have applied, and have been refused on academic
29 grounds, and it is possible that some of them may have
30 turned out to be excellent students of medicine, but this
is a University matter of policy.

COMMISSIONER VAN WART: Apropos of that,



...this gives them mobility
...not required to meet reciprocity.
COMMISSIONER VAN WART: Is the mortality

of the applicants vary much in this examination?
...
rate among foreign graduates is quite high. I am sorry
I haven't got the figures available at the moment, and I
believe the Medical Council of Canada will be submitting
these figures later, but the failure rate among British

among entrants, it is higher than those who graduate?
DR. WALTON: I don't think the failure
rate today is as high as it was formerly, and perhaps
this is due to a more rigid selection of students on
academic attainment, but the number of graduates is
certainly smaller than the number of entrants.

COMMISSIONER VAN WART: Do you feel that
the failure rate, or are you observing that more selec-
tive method of accepting students is keeping down the
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the factors, sir. I have known of individual students
who have applied, and have been refused on academic
grounds, and it is possible that some of them may have
turned out to be excellent students of medicine, but this

COMMISSIONER VAN WART: ...of that,



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3 the University of Manitoba is one of the few universities
4 that haven't got the number of students which they can
5 teach. They are not saturated. Do you think the entrance
6 requirements are a factor in the low number of students
7 attending the University?

8 DR. WALTON: Perhaps it is one factor, but
9 it does not account for the diminishing list of applicants.
10 For example, five or six years ago there was an average of
11 300 applicants for entry into medicine in Manitoba, of
12 which 70 would be accepted. I am told that each year
13 this figure has dropped until it is well below 200 now,
14 and a great many of these applicants are completely
unsuitable.

15 COMMISSIONER VAN WART: In other words,
16 you say there are applicants enough to fill the so-called
17 vacancies, but their standards are not adequate?

18 DR. WALTON: They are not adequate.

19 COMMISSIONER STRACHAN: Mr. Chairman, Dr.
20 Walton, do we understand that there is no general reci-
21 procity between Great Britain and the Medical Council of
22 Canada, but only between Great Britain and certain
provinces?

23 DR. WALTON: That is right sir. Licensing
24 is purely a provincial matter, and each province has
25 different methods. I believe there are four or five that
26 have reciprocity with Great Britain, and others for
27 various reasons have not. I am sorry, there are six
28 provinces. Alberta, Saskatchewan, Nova Scotia, Prince
29 Edward Island, Manitoba and Newfoundland all have reci-
30 procity with Great Britain. Two of these of course do

the University of Manitoba is one of the few universities that haven't got the number of students which they are required to have. The requirements are a factor in the low number of students attending the University?

DR. WALTON: Perhaps it is one factor, but it does not account for the diminishing list of applicants. For example, five or six years ago there was an average of 300 applicants for entry into medicine in Manitoba, of which 70 would be accepted. I am told that each year this figure has dropped until it is well below 200 now, and a great many of these applicants are completely unsuitable.

COMMISSIONER STRACHAN: In other words, you say there are applicants enough to fill the so-called vacancies, but their standards are not adequate?

DR. WALTON: They are not adequate.

COMMISSIONER STRACHAN: Mr. Chairman, Dr.

Walton, do we understand that there is no general reciprocity between Great Britain and the Medical Council of Canada, but only between Great Britain and certain provinces?

DR. WALTON: That is right sir. Licensing is purely a provincial matter, and each province has different methods. I believe there are four or five that have reciprocity with Great Britain, and others for various reasons have not. I am sorry, there are six provinces. Alberta, Saskatchewan, Nova Scotia, Prince Edward Island, New Brunswick and Newfoundland all have reciprocity with Great Britain. Two of these of course do



not have medical schools, that is P.E.I. and Newfoundland.

THE CHAIRMAN: Thank you very much Dr. Walton and Dr. Birt and Dr. Macfarland. We are very grateful to you for the help you have given us.

We will proceed with the submission of the Faculty of Dentistry of the University of Manitoba.

THE SECRETARY: The next one, sir, will be known as Exhibit 59.

--- EXHIBIT NO. 59: Submission of the Faculty of Dentistry of the University of Manitoba.



THE CHAIRMAN: Thank you very much, Dr.

Walton and Dr. Birt and Dr. Macdonald. We are very

grateful to you for the help you have given us.

be known as Exhibit 50.

--- EXHIBIT 10. 50: Submission of the Faculty of Dentistry
of the University of Manitoba.



SUBMISSION OF THE FACULTY OF DENTISTRY OF THE
UNIVERSITY OF MANITOBA

Appearances: Dr. H.H. Saunderson, President,
University of Manitoba
Dean Dr. J.W. Neilson
Mr. W.J. Condo
Dr. Israel Kleinberg
Dr. T.L. Marsh

DR. NEILSON: Mr. Chairman, my name is Neilson. I am the Dean of the Faculty of Dentistry of the University of Manitoba. May I first say, Mr. Chairman, that I bring the regret and apologies of President Saunderson, who is unable to be with us this morning owing to a previous commitment elsewhere. He did say he hopes to be down eventually if possible, and I hope you will accept this apology.

May I introduce my colleagues.

The Faculty of Dentistry of the University of Manitoba was established in 1957 and was the first such Faculty to be established in this country since 1917.

We anticipate that the Commission will receive recommendations on the need for new facilities for professional education in Canada. We would suggest, therefore, that the experience here in Manitoba will be of some interest to the Commission, and concrete evidence is provided of the impact which the establishment of a dental faculty has had on a province previously without such a faculty. (see Appendix A; see also Appendix B).

We also anticipate that the Commission will receive recommendations on the need for subsidization of students in professional faculties and we would respectfully direct the Commission's attention to such a

UNIVERSITY OF MANITOBA

UNIVERSITY OF MANITOBA

University of Manitoba
St. James' Hospital

Dr. T.L. Marsh
Dr. Israel Kinsberg
Mr. W.J. Condo

DR. WILSON: Mr. Chairman, my name is

Wilson. I am the Dean of the Faculty of Dentistry of the University of Manitoba. May I first say, Mr. Chairman, that I bring the regret and apologies of President Sanderson, who is unable to be with us this morning owing to a previous commitment elsewhere. He did say he hopes to be down eventually if possible, and I hope you will accept this apology.

May I introduce my colleagues.

The Faculty of Dentistry of the University of Manitoba was established in 1957 and was the first such Faculty to be established in this country since 1911. We anticipate that the Commission will receive recommendations on the need for new facilities for professional education in Canada. We would suggest, therefore, that the experience here in Manitoba will be of some interest to the Commission, and concrete evidence is provided of the impact which the establishment of a dental faculty has had on a province previously without such a faculty. (see Appendix A; see also Appendix B). We also anticipate that the Commission will receive recommendations on the need for subdivision of students in professional facilities and we would respectfully direct the Commission's attention to a



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3 plan of government subsidization here in the Province of
4 Manitoba. (see Appendix C).

5 The Faculty has based its recommendations
6 on dental "needs" and not on dental "demands". At
7 present 95% of the population "need" continuing dental
8 care, but only 30% "demand" it.

9 A major breakthrough on the research front
10 could completely alter the dimensions of the dental health
11 care problem in Canada. Only through research can the
12 incidence of dental disease be reduced to the point
13 where the availability of services would be adequate to
14 cope with the need for treatment. To achieve this goal
15 however, much greater support for research must be forth-
coming.

16 Existing facilities for and methods of
17 rendering dental health services are inadequate to meet
18 the current and future requirements in the fields of
19 prevention, diagnosis, treatment, and rehabilitation.

20 The efficiency and effectiveness of
21 existing facilities and methods must be improved, and
22 the number of patients receiving treatment must be substan-
23 tially increased at as low unit costs as possible. These
24 aims could be achieved if dentists were trained to make
25 maximum and integrated use of dental auxiliaries, such
as hygienists, chairside assistants and dental laboratory
technicians.

26 The Faculty appreciates that a comprehen-
27 sive attack on the problems of dental health may require
28 an expenditure of funds beyond that which can be under-
29 taken in the immediate future, and it has therefore
30

plan of government subsidization here in the Province of
Manitoba. (see Appendix C).

The Faculty has based its recommendations

on dental "needs" and not on dental "demands". At
present 35% of the population "need" continuing dental

care, but only 30% "demand" it.

A major breakthrough on the research front
could completely alter the dimensions of the dental health
care problem in Canada. Only through research can the
incidence of dental disease be reduced to the point
where the availability of services would be adequate to
cope with the need for treatment. To achieve this goal
however, much greater support for research must be forth-
coming.

Existing facilities for and methods of
rendering dental health services are inadequate to meet
the current and future requirements in the fields of
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the number of patients receiving treatment must be substan-
tially increased at as low unit costs as possible. These
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maximum and integrated use of dental auxiliaries, such
as hygienists, chairside assistants and dental laboratory
technicians.

Give attack on the problems of dental health may require
an expenditure of funds beyond that which can be under-
taken in the immediate future, and it has therefore



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3 proposed a phase type of program. (see Appendix D).

4 The Faculty's recommendations are based
5 on a forecast of 20 years, making maximum use of existing
6 teaching and research facilities, with additional support
7 where needed.

8 It is upon these bases then, that the
9 remaining portion of this section has been prepared in
10 the form of two recommendations along with the fifteen
11 proposals suggested to implement them.

12 Recommendation A:

13 that increased numbers of better educated,
14 better trained and more closely integrated
15 dental personnel, including practitioners,
16 teachers, research workers, hygienists,
17 chairside assistants, and dental laboratory
18 technicians be produced.

19 Recommendation B:

20 that increased support of dental research
21 be extended in the areas of both the basic
22 and the clinical sciences.

23 The following eleven specific proposals
24 are in support of Recommendation A.

25 A.1. A School of Dental Hygiene be esta-
26 blished at the earliest possible date
27 within the Faculty of Dentistry of the
28 University of Manitoba.

29 A.2. The training of chairside assistants
30 and dental laboratory technicians be esta-
blished on a more formal and integrated
basis under the auspices of a recognized

proposed a phase type of program.

The facilities recommendations are based on the assumption that the existing facilities are inadequate for the teaching and research facilities, with additional support where needed.

It is upon these bases then, that the remaining portion of this section has been prepared in the form of two recommendations along with the fifteen proposals suggested to implement them.

Recommendation A:

Last increased numbers of better educated, better trained and more closely integrated dental personnel, including practitioners, teachers, research workers, hygienists, dental assistants, and dental laboratory technicians be produced.

that increased support of dental research be extended in the areas of both the basic and the clinical sciences.

The following eleven specific proposals

are in support of Recommendation A.

A.1. A School of Dental Hygiene be established at the earliest possible date within the Faculty of Dentistry of the University of Manitoba.

The training of chairside assistants and dental laboratory technicians be established on a more formal and integrated basis under the auspices of a recognized



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3 teaching institution.

4 A.3. The training of undergraduate dental
5 students, hygienists, chairside assistants
6 and dental laboratory technicians include
7 specific instruction and experience in
8 functioning on an integrated basis, and
9 in order that this process of integrated
10 teaching may be carried out efficiently,
11 provision be made on the staff of the
12 Faculty of Dentistry for sufficient
13 numbers of fully trained auxiliaries.

14 A.4. Continuation courses be provided to
15 enable practising dentists and their auxi-
16 liaries to receive the above mentioned
17 training in integration.

18 A.5. More and better integrated teaching
19 of dentistry and dental students in hospi-
20 tals be implemented by the teaching hospi-
21 tals and the University of Manitoba.

22 A.6. A compulsory year in the form of a
23 supervised and salaried externship be added
24 to the present dental course.

25 A.7. Facilities for teaching in the Univer-
26 sity of Manitoba be expanded by a 10,000
27 square foot addition to the existing
28 building.

29 A.8. A two-year biological science and
30 preclinical dental course be established
at suitably located universities which
currently have no Faculty of Dentistry but

teaching institution.

A.3. The training of undergraduate dentists, students, hygienists, chiropodists, assistants

specific instruction and experience in functioning on an integrated basis, and in order that this process of integrated teaching may be carried out efficiently, provision be made on the staff of the

Faculty of Dentistry for sufficient

numbers of

A.4. Continuation courses be provided to enable practising dentists and their assistants to receive the above mentioned

training in integration.

A.5. More and better integrated teaching of dentistry and dental students in hospitals be implemented by the teaching hospitals and the University of Manitoba

A.6. A compulsory year in the form of a

to the present dental course.

A.7. Facilities for teaching in the University of Manitoba be expanded by a 10,000

square foot addition to the existing

A.8. A two-year biological sciences and preclinical dental course be established at suitably located universities which



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which do have a Faculty of Medicine with functioning basic science departments, as a means of compensating for the wastage which presently occurs in the first and second years of the dental curriculum and which results in unused teaching capacity in the third and fourth years of existing faculties of dentistry.

A.9. An adequate plan of scholarships, loans and bursaries be instituted to cover student costs of dental education, thus permitting academically qualified students from all economic levels to pursue dental careers.

A.10. An annual federal grant of at least \$500 be made to universities for each full-time student enrolled in their faculties of dentistry.

A.11. Matching capital grants be made available to university science departments including dental faculties on the same basis as those grants which are presently available to departments of liberal arts from the Canada Council.

B. The following four specific proposals are in support of Recommendation B.

B.1. More funds for clinical research be made available by the Federal Government and that these funds be administered as a separate and autonomous dental grant and in

which do have a Faculty of Medicine with
functioning basic science departments, as
a means of compensating for the waste
which presently occurs in the first and
second years of the dental curriculum
and which results in wasted teaching capa-
city in the third and fourth years of
existing faculties of dentistry.

A.9. An adequate plan of scholarships,
loans and bursaries be instituted to cover
student costs of dental education, thus
permitting academically qualified students
from all economic levels to pursue dental
careers.

A.10. An annual Federal grant of at least
\$500 be made to universities for each
full-time student enrolled in their Facul-
ties of dentistry.

A.11. Matching capital grants be made
available to university science departments
including dental facilities on the same
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made available by the Federal Government
and that these funds be administered as a
separate and autonomous dental grant and in



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a manner similar to that in which basic research funds are presently administered and dispensed by the National Research Council.

B.2. Facilities for dental research in the University of Manitoba be expanded by a 10,000 square foot addition to the existing building.

B.3. Graduate programs to train teachers and research workers be provided in Canada.

B.4. Institutes of dental research be established when required and preferably in conjunction with existing faculties of dentistry.

THE CHAIRMAN: Dr. Neilson, I must say that you have put forward a very intelligent and readable brief, and one that shows care in its preparation. In this matter of extension, is the only extension that you have recommended, a 10,000 square foot addition, you do that twice. Do you mean 20,000 feet altogether?

DR. NEILSON: Yes sir.

COMMISSIONER STRACHAN: Mr. Chairman, in paragraph 7 it is suggested the integrated use of dental auxiliaries, such as hygienists, chairside assistants and dental laboratory technicians. What at the present time is being done in Manitoba at least to bring that about? Can you see any immediate future solution to this problem?

DR. NEILSON: I would like to think that

a number similar to that in which dental
research funds are presently administered
and are under the National Research
Council

8.3. Facilities for dental research in
a 10,000 square foot addition to the
existing building.

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that you have put forward a very intelligent and reasonable
brief, and one that shows care in its preparation. In
this matter of extension, is the only extension that you
have recommended, a 10,000 square foot addition, you do
that twice. Do you mean 20,000 feet altogether?

DR. WILLIAMS: Yes sir.

COMMISSIONER STANLEY: Mr. Chairman, in
paragraph 7 it is suggested the integrated use of dental
auxiliaries, such as hygienists, chatelaine assistants
and dental laboratory technicians. What at the present
time is being done in Montana at least to bring that
about? Can you see any immediate future solution to this
problem?

DR. WILLIAMS: I would like to think that



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3 the future solution might lie in the implementation of a
4 recommendation such as this. . At the present time on the
5 matter of integration itself I am not sure that too much
6 is being done. . . Certainly something is being done to try
7 to further the training of chairside assistants and of
8 laboratory technicians through evening courses and continua-
9 tion courses of this type, but on the matter of integration,
10 as we visualize it sir, I don't think too much is being
11 done at the present time.

12 COMMISSIONER STRACHAN: Would these chair-
13 side assistants be admitted to the University with less
14 than the required qualifications?

15 DR. NEILSON: When you say the required
16 qualifications, you mean with less than University
17 entrance?

18 COMMISSIONER STRACHAN: Yes.

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Certainly something is being done to try

to further the training of outside assistants and of

tion courses of this type, but on the matter of integrat-

as we visualize it now, I don't think too much is being

done at the present time.

COMMISSIONER STRAWMAN: Would these train-

side assistants be admitted to the university with less

than the required qualifications?

DR. WELLSON: When you say the required

qualifications, you mean with less than university

entrance?



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DR. NEILSON: I would say no. Perhaps President Saunderson might have something to say.

COMMISSIONER STRACHAN: What hope is there of getting them in for training if those requirements are ---?

DR. NEILSON: I think at no place do we say it has to be within the University. We say a recognized teaching institution, and we would like to think that perhaps the scene of some of the training may be the Dental College building, but we are not certain it should be completely under the auspices of the University of Manitoba. I would rather doubt this.

COMMISSIONER STRACHAN: I am sure we all agree with the fact that assistants can increase production of dental services, if you want to use that term, and there is a reference in Appendix G and Appendix Q where it is suggested that with two chairs an increase of 67% results, and then it is added that some dentists manage to treat as many as four patients at one time. I have certainly recognized three-ring circuses as entertainment, but personally I cannot visualize a four-ring circus in a dental office. What would be your opinion of that? I think if the average man tried to practise dentistry in that manner the consumption of dental manpower would be greatly increased.

DR. NEILSON: I think my only comment on that would be that I would agree I would not like to be a patient in that office.

COMMISSIONER STRACHAN: A patient or the operator?

DR. MILLER: I would say no, perhaps

President Sanderson might have something to say.

COMMISSIONER STRACHAN: What hope is there

of getting them in for training if those requirements are

DR. MILLER: I think as far as we

say it has to be within the University. We say a recog-

nized teaching institution, and we would like to think

that perhaps the scene of some of the training may be the

Dental College building, and we are not certain it should

be completely under the auspices of the University of

Manitoba. I would rather doubt this.

COMMISSIONER STRACHAN: I am sure we all

agree with the fact that assistants can increase production

of dental services, if you want to use that term, and

there is a reference in Appendix G and Appendix F where

it is suggested that with two or three an increase of 5%

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to treat as many as four patients at one time. I have

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but personally I cannot visualize a further increase in

dental office. What would be your opinion of that? I

think if the average man tried to practise dentistry in

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DR. NEILSON: That is correct.

COMMISSIONER STRACHAN: I would hate to have the Commission assume that if we added three more chairs to every dental office in Canada that we would increase the amount of dentistry done?

DR. NEILSON: I don't think that is the intention.

THE CHAIRMAN: Reasonably, if you increase it to two you say you would have a very substantial increase in the output?

DR. NEILSON: Yes, sir.

COMMISSIONER STRACHAN: What, then, would you visualize as the ideal for the average operator or office in the way of assistants?

DR. NEILSON: May I ask Dr. Marsh to answer that question?

DR. MARSH: Mr. Chairman, from studies that were started in the closing years of the '40's by the United States Public Health Service and by many other studies that have been conducted at a later date, it has been suggested that for a single dentist probably the most efficient organization is with two completely independent operating set-ups, and a statistical figure of dental assistants -- I think it is 1.5. This, of course, really is because in other studies two dentists working in combination operating with three assistants between them -- each with his individual assistant, and one you may term as a floater -- has been strongly recommended and found to be quite efficient.

In the Royal Canadian Dental Corps, which

DR. WILSON: That is correct.
COMMISSIONER STRACHAN: I would hate to
have the Commission assume that if we added three more
chairs to every dental office in Canada that we would

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United States Public Health Service and by many other

studies that have been conducted at a later date, it has

been suggested that for a single dentist probably the

most efficient organization is with two completely independ-

ent operating set-ups, and a statistical figure of dental

assistants -- I think it is 1.5. This, of course, really

is because in other studies two dentists working in

combination operating with three assistants between them

-- each with his individual assistant, and one you may

term as a floater -- has been strongly recommended and

found to be quite efficient.

In the Royal Canadian Dental Corps, which



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3 I have recent knowledge of, it has now been for a matter
4 of some ten years policy to construct all new dental
5 installations on the basis of at least two set-ups, not
6 necessarily for two dentists, but three for two, and
7 similar combinations of this type. Other auxiliary
8 assistants may be most efficient and most effective
9 depending somewhat on whether the office is practising
10 a specialty of dentistry or not, but generally speaking
11 I think for practical purposes each dentist should have
12 available to him his own plus a standby set-up, and he
13 should have one assistant-plus, depending on the type of
office being operated.

14 COMMISSIONER STRACHAN: With outside
15 dental laboratory technician assistance?

16 DR. MARSH: Yes, sir.

17 COMMISSIONER STRACHAN: Coming back to
18 the question of assistants and referring to Appendix I,
19 do you not think that such courses as this will produce
20 a great many more dental assistants than trying to train
girls for a year at least under University auspices?

21 DR. NEILSON: I am not too sure, when you
22 said training assistants "like this" -- which way...?

23 COMMISSIONER STRACHAN: Well, I am
24 thinking of the 40-hour training to which you refer here.

25 DR. NEILSON: Yes, you mean the course
26 which is presently being done?

27 COMMISSIONER STRACHAN: Yes.

28 DR. NEILSON: And your question is whether
29 we would not train more under this system?

30 COMMISSIONER STRACHAN: Yes, and realizing



...on the basis of at least two set-ups, not
necessarily for two dentists, but three for two, and

assistants can be most efficient and most effective
depending somewhat on whether the office is practicing
a specialty of dentistry or not, but generally speaking
I think for practical purposes each dentist should have
available to him his own plus a standby set-up, and he
should have one assistant-plus, depending on the type of
office being operated.

Dental laboratory technician assistants?

COMMISSIONER STRACHAN: Coming back to
the question of assistants and referring to Appendix 1,
do you not think that such courses as this will produce
a great many more dental assistants than trying to train
girls for a year at least under University auspices?

DR. WELLS: I am not too sure, when you
said training assistants "like this" - which way...?

COMMISSIONER STRACHAN: Well, I am
thinking of the 40-hour training to which you refer here.
DR. WELLS: Yes, you mean the course

which is presently being done?

COMMISSIONER STRACHAN: Yes.

DR. WELLS: And your question is whether

we would not obtain more under this system?

COMMISSIONER STRACHAN: Yes, and realizing



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3 and recognizing the fact that there is a high consumption
4 rate of dental nurses.

5 DR. NEILSON: Well, I might say in connec-
6 tion with this particular course, and I think it is
7 mentioned here, that this is a course for existing chair-
8 side assistants. It is not for recruitment of assistants.
9 I think also it comes into this matter of planned immigra-
10 tion and so on. I would doubt very much if this sort of
11 thing could be taught by way of a 40-hour evening course.
12 I don't think there is any doubt but what you would have
13 more assistants trained under the system you visualize,
14 but in the overall picture we prefer the other type.

15 THE CHAIRMAN: Is it intended to repeat
16 this after the present course is finished?

17 DR. NEILSON: The one which is spoken of
18 here, sir?

19 THE CHAIRMAN: Yes, in Appendix I.

20 DR. NEILSON: Yes, it has been held every
21 year for three years now, and I imagine it will continue
22 as long as there is a demand.

23 COMMISSIONER STRACHAN: Do you feel this
24 course is causing longer retention of the assistants in
25 the offices at all?

26 DR. NEILSON: I would really not know. If
27 I venture an opinion I would say I don't think it would
28 make a great deal of difference. If the girl had other
29 plans, I don't think the fact she took this course would
30 make any difference.

31 COMMISSIONER STRACHAN: How do the dentists
32 feel?

DR. WELLSON: Well, I might say in connec-

tion with this particular course, and I think it is mentioned here, that this is a course for existing chair-side assistants. It is not for recruitment of assistants. I think also it comes into this matter of planned migration and so on. I would doubt very much if this sort of thing could be taught by way of a 40-hour evening course. I don't think there is any doubt but what you would have more assistants trained under the system you visualize, but in the overall picture we prefer the other type.

THE CHAIRMAN: Is it intended to repeat

this after the present course is finished?

DR. WELLSON: The one which is spoken of

here, sir?

THE CHAIRMAN: Yes, in Appendix I.

DR. WELLSON: Yes, it has been held every

year for three years now, and I imagine it will continue

as long as there is a demand.

COMMISSIONER STACHAN: Do you feel this

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make any difference.

COMMISSIONER STACHAN: How do the dentists



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4 DR. NEILSON: From all indications that
5 we have, I think they are quite well satisfied. I may
6 say it is a course which is largely sponsored by the
7 Manitoba Dental Association, and there may be some
8 questions you would like to direct to them.

9 THE CHAIRMAN: Dr. Neilson, we heard just
10 this morning from Dr. Walton in this matter of bursaries,
11 and his group thought that the restriction or condition
12 of asking the recipient to remain in practice in Manitoba,
13 or in an area of Manitoba, was detrimental to the full
14 functioning of the bursary system. I notice in Appendix
15 C that you refer to that, but I was wondering if you had
16 an opinion as to whether this imposing of conditions was
17 decreasing the use being made of the bursary system?

18 DR. NEILSON: Well, in reply to that
19 question I think we have mentioned that nine of our 95
20 students have taken advantage of this. We see with these
21 small numbers no falling off of the requests for assis-
22 tance. This is quite apart from the philosophical aspect
23 of the thing.

24 THE CHAIRMAN: But in a practical way are
25 you finding that students will not apply for a bursary
26 because it means they are asked to stay in Manitoba for
27 one year?

28 DR. NEILSON: I think this does apply in
29 certain cases. There are students who come in and ask
30 about what types of assistance are available, and when
they are told of the conditions they say, in effect, they
don't wish to tie up their futures in something of this
kind.

DR. WILSON: Now all indications that

we have, I think, are quite well satisfied. I say

say it is a course which is largely sponsored by the

Manitoba Dental Association, and there may be some

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THE CHAIRMAN: Dr. Wilson, we heard just

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of asking the recipient to remain in practice in Manitoba,

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C that you refer to that, but I was wondering if you had

an opinion as to whether this imposing of conditions was

decreasing the use being made of the purvey system?

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students have taken advantage of this. We see with these

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3 THE CHAIRMAN: Because my recollection of
4 the views expressed in the Atlantic Provinces was that
5 the idea of the condition appeared to be a sound one and
6 one that they were using in every case.

7 DR. NEILSON: Well, once more here, Mr.
8 Chairman, we have not had any students leave us as yet,
9 and we would like to think that each of these nine
10 students, when he leaves, will make good on this condition.
11 So, I am speaking here now without any experience with
12 our own graduates, but certainly there are some who are
13 reluctant to accept this type of aid. I am afraid I
14 couldn't tell you what the percentage is.

15 THE CHAIRMAN: I wonder if Dr. Saunderson
16 would have an opinion to give on this question of the
17 conditional berth?

18 DR. SAUNDERSON: Yes, Mr. Chairman. My
19 views on it are perhaps more conditioned from our
20 experience in the Faculty of Medicine where this type of
21 assistance has been available for many years. I think
22 there is no question whatever from our experience at the
23 University that many students who should receive assistance
24 under some form of bursary are reluctant to take a bursary
25 of this type which is tied into service after graduation
26 either within the rural areas or in the public health
27 service. There are many students who would like to
28 receive assistance and who should receive assistance who
29 are reluctant to determine their first two or three
30 years after graduation at an early stage in their course,
and I imagine the same thing would apply in dentistry.
We haven't yet had the position in dentistry with

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THE CHAIRMAN: I wonder if Dr. Sanderson

would have an opinion to give on this question of the

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DR. SANDERSON: Yes, Mr. Chairman. My

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experience in the Faculty of Medicine where this type of

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and I imagine the same thing would apply in dentistry.

We haven't yet had the position in dentistry with



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3 graduates coming out, as you know, sir.

4 THE CHAIRMAN: Thank you very much, Dr.
5 Saunderson.

6 COMMISSIONER VAN WART: Students who
7 receive this conditional bursary -- are they allowed to
8 continue the interneship before they go into the rural
9 districts, or must they go into the rural districts
10 right after they graduate?

11 DR. SAUNDERSON: In medicine the students
12 must complete their interneship before they go out and
13 practise in a rural district or under the public health
14 service. They are not registered with the College of
15 Physicians and Surgeons, the licensing body, until they
16 have completed their interneship. So, this is considered
17 really part of their course, and it is after that, and
18 only when they have completed that, that they are able to
19 go out into practice.

20 COMMISSIONER VAN WART: Are they allowed
21 to go on into advanced interneship before they go out?

22 DR. SAUNDERSON: In some cases they may
23 arrange to defer this service. This has been done in,
24 I think, several cases.

25 COMMISSIONER VAN WART: Dr. Neilson, in
26 A.6. you speak of a compulsory year in the form supervised
27 and salaried externeship to be added to the present
28 dental course: that is an undergraduate year you will be
29 adding?

30 DR. NEILSON: I think that would be it.

COMMISSIONER VAN WART: That would be one
year longer on the dental course?



Graduates coming out, as you know, sir.

THE CHAIRMAN: Thank you very much, Dr.

COMMISSIONER VAN WART: Students who

receive this conditional diploma -- are they allowed to

continue the internship before they go into the rural

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DR. NEILSON: Yes, sir.

COMMISSIONER VAN WART: Would you explain what type of work that would be?

DR. NEILSON: Well, we had felt when we talked about the matter of trying to have a better co-ordination of dental services and so on, that this would be rather difficult to put across in the present crowded curriculum, and we felt that it would be difficult to add on a year without some sort of stipend attached. We visualize this, I think, as what we have called a combined teaching service year, in which some dental services would be rendered to segments of the population. We have to some extent visualized it as an opportunity for further learning opportunities or occasions when, with a minimum supervision, the student, the externe, might be permitted to pursue some of these newer ideas in the matter of the use of auxiliaries, and so on.

COMMISSIONER VAN WART: Would it be equivalent to the compulsory medical internship?

DR. NEILSON: I think this is a fair comparison, yes.

COMMISSIONER STRACHAN: That would be following your final year now?

DR. NEILSON: Yes, sir.

COMMISSIONER STRACHAN: And where would you visualize that they would serve this externship -- in a public-type clinic or, if in a private office, it would certainly be limited to an office where there are at least two and preferably three chairs?

DR. NEILSON: This was the principal

DR. WILLSON:

COMMISSIONER VAN WART: Would you explain

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co-ordination of dental services and so on, but this
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COMMISSIONER VAN WART: Would it be advisable

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COMMISSIONER STACHAN: And where would

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reason for asking for a 10,000 square foot addition to the existing building for teaching purposes.

COMMISSIONER STRACHAN: You might hold this experience in the school then?

DR. NEILSON: For a certain portion of the year. We also felt that there would be some opportunity for them to move into certain other centres in the province where there would be some sort of supervision and they would have an opportunity of rendering service to types of patients which they don't normally have this opportunity for in the existing course. I think the aged and perhaps the mental hospital, and this type of thing, and certainly hospital teaching would play a part in this as well.

COMMISSIONER BALTZAN: Dr. Neilson, please excuse my innocence or ignorance: the proposition of the School of Hygiene is novel to me, and I refer to page 13, sub-section 1A(1). My question is this: is this an allied dental public health school, or would you describe it for me, please?

DR. NEILSON: I think it might help the situation if I were to define a dental hygienist. This is rather a difficult thing to do. I have tried to find a definition in a dictionary of a dental hygienist, but I think to some extent it must be defined by duty or responsibility, and I think this is a person who at the present time has undertaken a two-year course at an approved school of dental hygiene, and who is permitted to perform certain intra-oral operations either in the dental offices or in the governmental or state agency

reason for asking for a 12,000 square foot addition to the existing building for teaching purposes.

COMMISSIONER STACHUR: You might hold

this experience in the school there?

DR. NELSON: For a certain portion of the

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thing, and certainly hospital teaching would play a part

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COMMISSIONER STACHUR: I am

excuse my ignorance or ignorance: the proposition of the

School of Hygiene is novel to me, and I refer to page 18,

sub-section (A)(1). My question is this: is this an

affiliated dental public health school, or would you describe

it for me, please?

DR. NELSON: I think it might help the

situation if I were to define a dental hygienist. This

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present time has undertaken a two-year course at an

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under the supervision of a dentist. The duties which
may be performed intra-orally are principally the
scaling and polishing of teeth, the taking of dental
x-rays; in certain provinces the application of topical
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McH/dpw

Governmental agencies, I think your principal function is a self-education one.

COMMISSIONER BALTZAN: It is not then exactly a post-graduate school for dentists?

DR. NEILSON: No, sir.

COMMISSIONER BALTZAN: And it is not exactly a research school for the basic sciences related to dentistry?

DR. NEILSON: No sir, it is a school for dental auxiliaries.

COMMISSIONER BALTZAN: Lastly, would you be good enough to refresh my memory, what is the length of the present course of the dental school?

DR. NEILSON: In Manitoba there are two pre-dental years, these are minimum two pre-dental years following junior matriculation and then a four-year dental course so it is a six-year stand following junior matriculation.

COMMISSIONER BALTZAN: With your present requirements your suggestion of an internship, would that be sort of a compulsory inclusive thing and would lengthen your course to seven years?

DR. NEILSON: Yes, sir.

COMMISSIONER STRACHAN: You have mentioned a figure of 95 students and my understanding is that you have a capacity for at least 30 students per year, therefore your student body is at the present time 25 under the possible number you might have?

DR. NEILSON: Yes, sir.

COMMISSIONER STRACHAN: What has been your

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COMMISSIONER BALDWIN: It is not then

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requirements your suggestion of an internship, would

that be sort of a compulsory inclusive thing and would

lengthen your course to seven years?

DR. WELSON: Yes, sir.

COMMISSIONER STRACHAN: You have mentioned

a figure of 85 students and my understanding is that

you have a capacity for at least 80 students per year,

therefore your student body is at the present time 25

under the possible number you might have?

COMMISSIONER STRACHAN: What has been your



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3 experience so far in filling classes?

4 DR. NEILSON: Well, our figures speak
5 for themselves. I think the initial class was not
6 filled by any means and, in fact, this past year has
7 been the first year in which we have a full class.
8 Actually we have an overflow class in that we accepted
9 33 students rather than the 30. In our first year we
10 accepted 22 and if you look at the figures there are 15
11 in fourth year, 20 in third year, 27 in second year and
12 32 in first year.

13 COMMISSIONER STRACHAN: Could you give us
14 any idea of the number of applicants who have been
15 refused?

16 DR. NEILSON: This again is a rather diffi-
17 cult question. We prepare our application list sometimes
18 before we have the results of the final examinations in
19 April at the University. A person who might appear to be
20 a bona fide applicant on April 1st before his final exami-
21 nations, when the results come in and he has failed three
22 or four examinations he is no longer an applicant as such.
23 By taking into consideration those names of all those
24 people our applicant lists have already ranged between
25 85 and 95 each year except the first year when I think
26 there were 68 names on that list.

27 COMMISSIONER STRACHAN: But you are able
28 to handle 30 satisfactorily?

29 DR. NEILSON: Yes sir, that is true, and
30 I think the results bear this out. We admit the student
who comes in with the lowest average is usually the one
who gives us the trouble in the Faculty. When I say

DR. WILSON: Well, our first year class

was not

filled by any means and, in fact, this past year has

been the first year in which we have a full class.

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"trouble" I mean academic trouble.

COMMISSIONER STRACHAN: Than the turn-out on the basis of academic standing?

DR. NEILSON: Yes. There is very little of a consideration there. There are certain considerations as to place of residence and so on.

COMMISSIONER STRACHAN: What standard do you try to maintain?

DR. NEILSON: The University calendar says a student who has less than 65% overall average is not encouraged to apply for the Faculty of Dentistry. This percentage, I would say, has been dropped in every year and I were to pick a percentage I would say the critical average is now about 60% on pre-dental work.

COMMISSIONER VAN WART: We heard in the last submission that they had an adequate number of applications but the standards would only permit them to take a certain number of students and did not fill to capacity. I understand from your statement that you have an adequate number of applications but not applications of a standard which your school wishes to accept?

DR. NEILSON: I think that is so.

COMMISSIONER VAN WART: That occurring in two faculties looks to me as if the root of the problem is in the preparation of your students in the pre-medical courses or in the high school courses. To me this would seem that the courses are not adequate to keep your schools at your capacity. It all goes back to the training schools or your standards are too high. It is not a question of bursaries or anything else, it is a

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3 question of preparation of students. I do not know
4 whether you agree with that or not.

5 DR. NEILSON: I think this is certainly
6 part of the answer.

7 COMMISSIONER VAN WART: Have you any
8 comment to make on that, Dr. Saunderson?

9 DR. SAUNDERSON: Yes, Mr. Commissioner, I
10 would agree in part with what you say. This is based on
11 experience both in medical and dental schools where we
12 have the same type of problem. We do find that students
13 will apply for either medicine or dentistry who are
14 obviously ill-prepared to enter either of these profes-
15 sional groups. I can recall individual cases of students
16 who have been in the University and have failed one year
17 or even two years who thought they were going to be fit
18 applicants and made application for admission to one or
19 other of these two schools. I can recall one particular
20 case of a student who applied and in checking his record
21 we found he had 17 supplementals in his, in this case,
22 pre-medical program. Obviously he was not qualified for
23 entry into a good professional school and he did not get
24 in, of course. But, we do have a number of applications
25 from people who I would regard as completely nonsensical
26 applications, people who obviously do not have any qualifi-
27 cations. I will admit that such a person should not have
28 applied at all, he should never have been on the list of
29 applicants because you could see he was badly prepared.
30 I would agree that if he was badly prepared then he just
did not have the inherent background. If these people
are admitted it has been our experience that they come to

whether you agree with that or not.

WELLS: I think this is certainly

part of the answer.

COMMISSIONER VAN HANDEL: Have you any

comment to make on that, Dr. Davidson?

DR. S. J. DAVIDSON: Yes, Mr. Commissioner, I

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4 academic grief in the early years of their professional
5 course, either in medicine or dentistry. That is why we
6 have many more applications than people admitted even
7 though we may have less than a complete quota for the
8 school.

9 If any of the Commissioners would like to
10 ask me why these people with their bleak looking records
11 would apply, I have to admit I have not the vaguest idea;
12 I suppose it is a matter of hope.

13 COMMISSIONER FIRESTONE: If I might follow
14 this up a little; as we understand it both your school
15 of medicine and your school of dentistry has some room
16 to train some more people. You have the facilities, the
17 teaching staff and all the other additional requirements.
18 You also know that in other provinces some of the medical
19 centres have more applications than they can accept inclu-
20 ding people of high calibre. The demand is, in some
21 medical centres, greater than the available facilities and
22 they may want to accept them but they just cannot. It
23 seems to me there is a bit of a hiatus in Canada where we
24 have medical schools and dental schools with greater
25 capacity than the number of students that are registered
26 and other schools that have more applications of qualified
27 students than they have facilities for. I am wondering
28 whether the University of Manitoba in its medical and
29 dental school is doing anything to advise potential
30 medical or dental students in other universities of the
facilities that are available, the bursaries that are
available and the opportunities that exist in Manitoba.

DR. SAUNDERSON: We have done a bit of that



academic field in the early years of their professional course, either in medicine or dentistry. That is why we have many more applications than people admitted even though we may have less than a complete quota for the

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COMMISSIONER THIRSK: If I might follow

this up a little; as we understand it both your school of medicine and your school of dentistry has some room to train some more people. You have the facilities, the teaching staff and all the other additional requirements. You also know that in other provinces some of the medical centres have more applications than they can accept including people of high calibre. The demand is, in some medical centres, greater than the available facilities and they may want to accept them but they just cannot.

seems to me there is a bit of a hiatus in Canada where we have medical schools and dental schools with greater capacity than the number of students that are registered and other schools that have more applications of qualified students than they have facilities for. I am wondering whether the University of Manitoba is the medical and dental school is doing anything to realise potential medical or dental students in other universities of the facilities that are available. The programs that are available and the opportunities that exist in Manitoba.

DR. SAUNDERS: We have done a bit of



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3 and our experience in general has not been very satisfac-
4 tory in this field. I can recall, and this applies in
5 the Faculty of Dentistry and Dean Neilson can confirm
6 what I have to say, in the early years I think it was the
7 first or second year of our school we actually established
8 contact with the pre-professional committee or whatever
9 name the University had for people going into this to
10 get applications from good people. In one particular
11 university in Western Canada which did not have a Faculty
12 of Dentistry at all we had a list, I think, of seven
13 names which they had recommended and they forwarded appli-
14 cations. Three or four of these proved to be good and
15 we accepted them but they did not show. In some cases
16 they wrote to us well ahead of the September opening and
17 in some cases we were informed only at the very last
18 minute that they did not plan to come to Manitoba. There
19 are problems. I think probably the members of the
20 Commission will realize and no doubt have heard this
21 from other schools in the east, as you have been visiting
22 the east, that a great many students make application at
23 their pre-medical point or the pre-dental point to four,
24 five, six or seven different schools and they may get
25 acceptances from three or four of these. Obviously they
26 can go to only one. I think part of our difficulty has
27 been from students who have applied to and have been
28 accepted at several different schools and they generally
29 take the one which is closer to their home base than
30 Manitoba would be. I think it is worth pointing out and
the information is quite clear that in the last year or
two the number of qualified people who are applying to and

the Faculty of Dentistry and Dean Nelson can confirm
what I have to say, in the early years I think it was the
first or second year of our school we actually established
contact with the pre-professional committee on whatever
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get applications from good people. In one particular
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cations. Three or four of these proved to be good and
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minute that they did not plan to come to Manitoba. There
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accepted at several different schools and they generally
take the one which is closest to their home base than
Manitoba would be. I think it is worth pointing out and
the information is quite clear that in the last year or
two the number of qualified people who are applying to a



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3 being admitted to Manitoba is climbing both in dentistry
4 and medicine. This year we took in 66 students in
5 medicine. We went through a period of seven years and
6 I think our experience was similar to that to a number
7 of other medical schools in Canada and the United States
8 where there was a dearth of good applicants but there
9 now seems to be an upward trend. This year we accepted
10 66 or 67 in medicine and 33 in dentistry which was
11 really three over our quota but these people looked good
12 and we felt we could handle them.

13 COMMISSIONER FIRESTONE: I take it notwith-
14 standing the difficulties you have encountered, you
15 continue to attract students from other universities to
16 come to your school?

17 DR. SAUNDERSON: Yes.

18 COMMISSIONER FIRESTONE: Would you feel
19 the University of Manitoba would be in favour of a
20 national scholarship plan for medical students without
21 strings attached of the type that are attached to provin-
22 cial scholarships or bursaries?

23 DR. SAUNDERSON: I would say so if you are
24 asking me because in actual fact while in medicine there
25 are medical schools in most of the provinces - admittedly
26 in the Atlantic Provinces there are several provinces
27 without it but in the central and western parts they all
28 have one - in dentistry that is not the case. It is
29 quite understandable and reasonable that we, as one of
30 the provinces with a dental school, should provide some
service, if you like, on an inter-provincial basis or,
to put it alternatively, on a national basis for the

We went through a period of seven years and I think our experience was similar to that to a number of other medical schools in Canada and the United States where there was a dearth of good applicants but there now seems to be an upward trend. This year we accepted 66 or 67 in medicine and 33 in dentistry which was really three over our quota but these people looked good and we felt we could handle them.

standing the difficulties you have encountered, you continue to attract students from other universities to come to your school?

DR. SAUNDERS: Yes.

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3 Canadian people. I agree with your association that
4 this might be a national plan.

5 COMMISSIONER FIRESTONE: I take it such a
6 national plan, in your opinion, would contribute to an
7 increase in the number of students attending your medical
8 and dental faculties?

9 DR. SAUNDERSON: I would think so.

10 COMMISSIONER FIRESTONE: Dean Neilson, may
11 I turn to paragraph 4 of the summary of your submission
12 on page 1 where you distinguish between 95% of the popula-
13 tion being in need of continued dental care and you refer
14 to only 30% demanding it. I take it the 95% covers
15 people who in the opinion of the dental profession in
16 the Province of Manitoba should be getting dental care
17 and the 30% refers to the people who are actually getting
18 it?

19 DR. NEILSON: I think that is correct, yes.

20 COMMISSIONER FIRESTONE: Would you say one
21 of the main reasons for this difference of 30% and 95%
22 are economic reasons, that a number of people cannot
23 afford to pay for these dental services?

24 DR. NEILSON: That is a very difficult
25 question to answer. I do not know if this helps the
26 situation, and this might come up in some other part of
27 the submissions of other representative organizations,
28 but I do know in the Medicare Plan in the Province of
29 Manitoba in which there is no deterrent fee for dental
30 services and which covers, I think, something between
15,000 and 13,000 people, that the usage of this plan has
only been about 19%. This is something that shows

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this might be a national plan.

COMMISSIONER FIRESTONE: I take it such a

national plan, in your opinion, would contribute to an increase in the number of students attending your medical

and dental facilities?

DR. SALMONSON: I would think so.

COMMISSIONER FIRESTONE: Dean Neilson, may

I turn to paragraph 4 of the summary of your submission on page 1 where you distinguish between 88% of the population being in need of continued dental care and you refer

to only 30% demanding it. I take it the 88% covers

people who in the opinion of the dental profession in

the Province of Manitoba should be getting dental care

and the 30% refers to the people who are actually getting

it?

DR. NEILSON: I think that is correct, yes.

COMMISSIONER FIRESTONE: Would you say one

of the main reasons for this difference of 80% and 88%

are economic reasons, that a number of people cannot

afford to pay for these dental services?

DR. NEILSON: That is a very difficult

question to answer. I do not know if this helps the

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the submissions of other representative organizations,

but I do know in the Medicare plan in the Province of

Manitoba in which there is no deterrent fee for dental

services and which covers, I think, something between



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3 economics do not play a part, I think there are equally
4 good reasons but I am not saying that economics are not
5 important.

6 COMMISSIONER FIRESTONE: You say there are
7 some reasons which suggest economics are a factor?

8 DR. NEILSON: Yes.

9 COMMISSIONER FIRESTONE: Would you feel
10 if there were a prepaid dental plan in operation in the
11 Province of Manitoba this would contribute to reducing
12 the gap between the 30% and 95% which you observe?

12 DR. NEILSON: I would think it might, yes.

13 COMMISSIONER FIRESTONE: Would you feel,
14 and perhaps this is a question that is addressed more to
15 you as a dentist than as a Dean of the dental school;
16 would you feel that the dental profession would be in
17 favour of a prepaid dental plan?

18 DR. NEILSON: Here again I think I would
19 feel somewhat the same as others, I think, who have
20 spoken. I think the mechanics of it and the regulations
21 governing it would be of considerable importance. If
22 these were right, I think there is much to be said for
23 the principle of prepaying.

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economics do not play a role. I think there are equally

important.

COMMISSIONER LINDSTROM: You say there are

some reasons which suggest economics are a factor?

COMMISSIONER LINDSTROM: Would you feel

if there were a prepaid dental plan in operation in the
Province of Manitoba this would contribute to reducing

the gap between the 30% and 65% which you observe?

MR. LINDSTROM: I would think it might, yes.

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COMMISSIONER FIRESTONE: In other words, you are in favour of the principle, but you want to be sure that the method that is employed is adequate and satisfactory?

DR. NEILSON: Yes sir.

COMMISSIONER FIRESTONE: May I now turn to paragraph 7, in which you speak of the integrated use of dental auxiliaries. You gave us a definition of dental hygienists. Forgive me as a layman if I restate the question in my own terms. Would you say the dental auxiliaries are people that are allowed to perform functions which involve activity inside the mouth of a patient?

DR. NEILSON: I think using the word auxiliary in our context there are perhaps three classes of auxiliaries. There is the dental laboratory technician, the chairside assistant, and the hygienist. Of these three, the only one at the present time who is legally permitted to perform intra-orally is the third, the dental hygienist.

COMMISSIONER FIRESTONE: What does the chairside assistant do?

DR. NEILSON: She is the person who does what the name implies, stands by the side of the chair, hands the operator instruments, assists him in ways which are suitable and which have been worked out in instruction and by trial and error.

COMMISSIONER FIRESTONE: You would say that the dental hygienist then is a person who is permitted to perform functions inside the mouth by law?

DR. NEILSON: Yes sir.

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DR. WILSON: Yes sir.

COMMISSIONER FIRSTONE: May I now turn to
paragraph 7, in which you speak of the integrated use of
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COMMISSIONER FIRSTONE: You would say that

the dental hygienist then is a person who is permitted
to perform functions inside the mouth by law?

DR. WILSON: Yes sir.



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4 COMMISSIONER FIRESTONE: Is this law just
5 applicable to the Province of Manitoba, or are other
6 similar provisions in existence in all other nine
7 provinces?

8 DR. NEILSON: I am not sure that there is
9 such legislation in every other province. I believe
10 there are one or two provinces in which there is no legis-
11 lation, but I would say that the great majority of
12 provinces have this legislation.

13 COMMISSIONER FIRESTONE: And you would
14 feel that by increasing the number of dental hygienists
15 you can extend the services quite substantially as long
16 as that increase in the number does not produce a four-
17 ring circus, as my fellow Commissioner suggested, but
18 within reason you feel it could significantly increase
19 the dental services provided to the people of Manitoba?

20 DR. NEILSON: Yes sir.

21 COMMISSIONER FIRESTONE: Thank you very
22 much. I have one last question, Dean Neilson. Do
23 dentists in Manitoba practise in group practice?

24 DR. NEILSON: To some extent. In my
25 experience, which ranges over particularly the western
26 provinces, I think there is more group practice perhaps
27 in the City of Winnipeg than in any other city in western
28 Canada. I have no figures to support this, but there is
29 a certain amount of it done.

30 COMMISSIONER FIRESTONE: There is therefore
group practice in dentistry in Greater Winnipeg?

DR. NEILSON: There is a certain amount of
it.

COMMISSIONER FIRSTONE: Is this law just

applicable to the Province of Manitoba, or are other
similar provisions in existence in all other nine

such legislation in every other province. I believe

there are one or two provinces in which there is no legis-

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DR. WILLSON: There is a certain amount of



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4 COMMISSIONER FIRESTONE: Can you tell us
5 some of the advantages in group practice in dentistry,
6 both to the dentist and the patient?

7 DR. NEILSON: I have never been in group
8 practice, and I am merely repeating what I have heard
9 sometimes when enthusiasts speak of it. I think there
10 is an advantage in that there is a sharing of responsibi-
11 lity, and there is an opportunity within the group to
12 develop certain interests of a semi-specialist nature,
13 and which a person who has a flair for taking care of
14 children can do so, and also there is the advantage to
15 the dentist of having someone to whom he can turn over
16 his responsibilities when he has to be away from the
17 office, and this sort of thing. And I think there are
18 certain sharing of, Dr. Marsh mentioned it, of assistants,
19 waiting room space, rather expensive equipment, and so
20 on.

21 COMMISSIONER FIRESTONE: In other words,
22 you are suggesting to us that group practice may be a
23 more efficient system of practising dentistry?

24 DR. NEILSON: I think this is a more
25 efficient system, yes.

26 COMMISSIONER BALTZAN: Have you given
27 thought to condensing the curriculum in order to shorten
28 the length of time to obtain a dental degree?

29 DR. NEILSON: We have thought of this.
30 Certainly the curriculum is crowded at the moment. We
have worked it out that the dental student spends 38.5
hours per week in formal instruction, and this we think
is a great deal. This does not help the situation, but



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4 I heard an educationalist say one time it takes almost
5 as long to change a curriculum as it does to move a grave-
6 yard, and I think this is the problem we face. We are
7 certainly anxious to try and shorten it. We have it
8 under reference. We are a new faculty, and we are trying
9 to do this sort of thing, which is easier in a long-
10 established faculty. We certainly haven't been too
11 successful.

12 COMMISSIONER BALTZAN: Do you think it
13 might be possible?

14 DR. NEILSON: I would doubt it.

15 COMMISSIONER McCUTCHEON: In answer to
16 Dr. Firestone's question relating to paragraph 4 of
17 your summary, I take it although you didn't quite put it
18 this bluntly, you are suggesting that one reason for the
19 gap between need and demand was the natural reluctance
20 of people to go to dentists?

21 DR. NEILSON: Yes, I daresay this plays
22 a part.

23 COMMISSIONER McCUTCHEON: And I suppose
24 also the lack of knowledge of the importance of dental
25 care?

26 DR. NEILSON: Yes sir.

27 COMMISSIONER McCUTCHEON: Assuming 95%
28 of the population who need dental care were to be
29 suddenly - have the desire - and if necessary the finan-
30 cial ability to demand that care, is there any possibility
that you could cope with it in a reasonable period in the
Province of Manitoba?

DR. NEILSON: I think it would be, with

[Faint, mostly illegible text at the top of the page, possibly bleed-through from the reverse side.]

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to do this sort of thing, which is easier in a long-
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successful.

COMMISSIONER BALTZAN: Do you think it

might be possible?

DR. WILLSON: I would doubt it.

COMMISSIONER MCCUTCHON: In answer to

Dr. Finestone's question relating to paragraph 4 of
your summary, I take it although you didn't quite put it
this plainly, you are suggesting that one reason for the
gap between need and demand was the natural reluctance
of people to go to dentists?

DR. WILLSON: Yes, I guess this plays

a part.

COMMISSIONER MCCUTCHON: And I suppose

also the lack of knowledge of the importance of dental
care?

DR. WILLSON: Yes sir.

COMMISSIONER MCCUTCHON: Assuming 55%

of the population who need dental care were to be
suddenly - have the teeth - and if necessary the finan-
cial ability to demand that care, is there any possibility
that you could cope with it in a reasonable period in the

DR. WILLSON: I think it would be, with



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3 those assumptions that you have mentioned, I think this
4 would be a very, very difficult problem.

5 COMMISSIONER McCUTCHEON: That being the
6 case, assuming there might be priorities in any develop-
7 ment as you suggest yourself, where, in your opinion,
8 should the real emphasis be put initially, on the provi-
9 ding of additional personnel, or on research, supposing
10 you had to choose between those two?

11 DR. NEILSON: This is on the basis, sir,
12 that there is no longer any barrier to patients coming
13 to the dentist? That is your assumption?

14 COMMISSIONER McCUTCHEON: No, I am sorry.
15 Yes, we will put it on that assumption, yes.

16 DR. NEILSON: Well, I think that on that
17 assumption one has to face up to the immediate problem,
18 which as you pointed out, there is a widespread public
19 appreciation of the dental services under your proposal,
20 and there is no economic barrier, well, we all recognize
21 that research is going to take perhaps years to develop
22 answers, and I think then we have to face up to this
23 problem of immediate service by the practitioner.

24 COMMISSIONER McCUTCHEON: Well, I am
25 really not making myself clear then. Let us take another
26 assumption. Let us assume that the present situation
27 exists, that public education goes on as a continuing,
28 rather slow, process, that there is no drastic and sudden
29 demand for dental care, but there may be a steadily
30 increasing one. Where then do you place the emphasis?

31 DR. NEILSON: On that basis then I would
32 say research, from the Faculty's point of view.

assumptions that you have mentioned, I think this would be a very, very difficult problem.

COMMISSIONER MONTGOMERY: That being the

case, assuming there might be priorities in any develop-

ment as you suggest yourself, where, in your opinion,

should the emphasis be put? In the field of research, or in the field of additional personnel, or in research, supposing

you had to choose between those two?

MR. MONTGOMERY: This is on the basis, sir,

that there is no longer any barrier to patients coming

to the dentist, that is your assumption?

COMMISSIONER MONTGOMERY: No, I am sorry.

Yes, we will put it on that assumption, yes.

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and there is no economic barrier, well, we all recognize

that research is going to take perhaps years to develop

answers, and I think then we have to face up to this

problem of immediate service by the practitioner.

COMMISSIONER MONTGOMERY: Well, I am

really not asking myself what is then. Let us take another

assumption, let us assume that the present situation

exists, that public education goes on at a continuing,

rather slow, process, that there is no training and education

demand for dental care, but there may be a steadily

increasing one. Where then do you place the emphasis?

MR. MONTGOMERY: On that basis then I would

say research, from the future's point of view.



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4 COMMISSIONER McCUTCHEON: You say in
5 paragraph 8: "The Faculty appreciates that a comprehensive
6 attack on the problems of dental health may require an
7 expenditure of funds beyond that which can be undertaken
8 in the immediate future, and it has therefore proposed a
9 phase type of program". I must confess that I am not
10 sure what this program is. What are the phases?

11 DR. MARSH: In essence, sir, Mr. Chairman,
12 if you would look at page 4 of Appendix D ---

13 COMMISSIONER McCUTCHEON: That is what I
14 didn't understand.

15 DR. MARSH: You will notice that the items
16 are listed and separated into three groups, by vertical
17 lines. The bottom of the group on the immediate left is
18 the proposals for research. The next for teaching and
19 integration of personnel, and the last are financial.
20 If we go to the top line listed Phase I, it would be, the
21 items lying right across the whole line of Phase I there,
22 ideally they should all be implemented at the same time,
23 but recognizing this may not be possible we wish to give
24 the Commission what might be implemented and form part
25 of a composite group. In other words, we would not have
26 the cart ahead of the horse in certain areas. I will let
27 Dr. Kleinberg speak to the research portion.

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28 If we may take the Teaching and Integration
29 of Personnel portion in the centre. For example, item A7
30 is a request for the 10,000 additional feet of space for
teaching purposes, and below that, item A6 is the extern-
ship. Now, it would be quite impossible to implement the
externship without the space in which to carry out the

phase type of program". I must confess that I am not
sure what this program is. What are the phases?

if you would look at page 4 of Appendix B ---
COMMISSIONER McWOMON. That is what I

DR. MARSH. You will notice that the items

are listed and separated into three groups, by vertical
lines. The bottom of the group on the immediate left is
the proposals for research. The next for teaching and
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If we go to the top line listed Phase 1, it would be, the
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but recognizing that may not be possible we wish to give
the Commission what might be implemented and form part
of a composite group. In other words, we would not have
the cant ahead of the house in certain areas. I will let
Dr. Kleiberg take the second question.

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4 procedure. Immediately to the right, in item A1 is the
5 hygienist. If all items, A2, A6 and A1 were implemented,
6 the question of space is absolutely essential. It would
7 be possible to implement item A1 within the existing
8 framework. If there were no 10,000 feet of space added,
9 it does not necessarily mean the hygiene program could
10 not be continued. By the same token, the Faculty's
11 physical facilities in the training of laboratory assis-
12 tants, which is item A2, again while it would play a
13 part and make it possible to end up with the externship,
14 you would have hygienists adequately trained, chairside
15 assistants adequately trained, and laboratory assistants
16 adequately trained, all brought together in an atmosphere
17 to teach the dentist with them how to make the best of
18 this. You could implement them independently, but you
19 could not implement item A6 if you had not previously
20 implemented item A3.

21
22 COMMISSIONER McCUTCHEON: That would follow
23 through then for A4, you must first implement A7 and A6?

24
25 DR. MARSH: That is correct.

26
27 DR. KLEINBERG: Sir, the same principle
28 would apply under the proposals which have been recommended
29 for the research. In Phase I we have item B2, B3, and
30 B1, which represent space, training program and our
clinical research. Before one could actually, B3 could
be implemented fairly early, one would require the facili-
ties for this program, and consequently B2 would come in
and B1, clinical research is necessary before one could
properly utilize A5, the integration into the hospitals
and research in the hospitals.



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4 COMMISSIONER McCUTCHEON: In other words,
5 you must do Phase I in Research before you drop down to
6 Phase II, Teaching and Integration of Personnel?

7 DR. KLEINBERG: And where certain phases
8 come before others, in Phase I, the training program does
9 not till a fairly late phase, Phase III would come up
10 with so-called institutes.

11 COMMISSIONER McCUTCHEON: A8, A9, A10 and
12 All, I take it, can be implemented immediately, and bear
13 no relation to the other parts of the program?

14 DR. KLEINBERG: Yes.

15 COMMISSIONER STRACHAN: Mr. Chairman, I
16 don't wish to labour this point, but coming back to 4,
17 on page 1, I think some clarification should be made here,
18 and I think Dean Neilson would agree with it, that when
19 you say 30% demanded, you mean 30% demand adequate treat-
20 ment and it does not mean that the 65 or 70% outside of
21 that 30% do not receive any dental treatment at all.
22 That number never appear in a dental office. They do
23 appear for emergency or urgent treatment?

24 DR. NEILSON: I think that is correct.

25 THE CHAIRMAN: Thank you very much, Dr.
26 Neilson, and the gentlemen with you, and particularly
27 you, Dr. Saunderson, for being of such help to us here
28 this morning.

29 Ladies and gentlemen, we are going to take
30 a five-minute break, and we will then proceed with the
submission of the Manitoba Dental Association.

--- Short Recess



SUBMISSION OF THE MANITOBA DENTAL ASSOCIATION

Appearances: Dr. W.I. Jackson, immediate
Past-President of the Manitoba
Dental Association
Dr. W.G. Campbell, Secretary-
Registrar of the Manitoba Dental
Association
Dr. R. Connor, Director of Dental
Services, Department of Health,
Manitoba
Dr. C. McCormick, Director of
Dental Services, City of Winnipeg
Dr. T.J. Cooke, Chairman of the
Committee preparing brief to
Royal Commission

DR. JACKSON: Mr. Chairman, Dr. Cooke
has been the Chairman of our Committee which prepared
our brief, and, as chief architect of our brief, and
with your permission sir, I would ask that he may read
the recommendations and conclusions of our brief and act
as spokesman when it comes to questions from the Commis-
sion.

DR. COOKE: CONCLUSIONS AND RECOMMENDA-
TIONS:

The brief presented to the Royal Commission
on Health Services by the Manitoba Dental Association
represents as much as possible the views of the whole
dental profession in this province. The information
has been gathered from all available sources and not only
the board of the Association but many other individuals
and committees have participated.

We believe the brief shows:

1. THAT the standard of dental health in
this province is not at a high level.

2. THAT this is largely due to lack of
dental health education and to apathy on the part of the



1
2
3 population.

4 3. THAT there are not enough dentists
5 licensed in this province to meet the present demand for
6 treatment and that this situation is a much greater
7 problem in the rural areas than in the urban centres.
8 There has been no improvement in this connection as far
9 as private practice is concerned over the past ten years.

10 4. THAT environmental and geographical
11 factors create some problems both in the provision of
12 dental treatment and in educating the public to a need
13 for better dental health standards.

14 5. THAT we would be in a worse position
15 if many of our men who are past normal retirement age
16 were not still practising.

17 6. THAT we do not have enough certified
18 specialists in the province nor enough men in private
19 practice with special training in dental public health,
20 orthodontia, periodontia and paedodontia.

21 7. THAT while approximately half the
22 population of the province reside outside the Metropolitan
23 Winnipeg area only one-quarter of the dentists are located
24 in that part of the province.

25 8. THAT there is a real problem in
26 finding suitable practice locations for a dentist outside
27 the large centres. According to the best evaluation we
28 are able to make, the addition of 15 dentists outside
29 the Metropolitan Winnipeg area would fill all the
30 suitable locations.

31 9. THAT the profession believes in the
32 greater use of auxiliary help and in the expansion of



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3 their duties under certain circumstances.

4 10. THAT there should be proper organiza-
5 tion and standards of qualifications and training set up
6 for laboratory technicians and chair assistants.

7 11. THAT we believe the Dental Public
8 Health program in this province has improved greatly in
9 the past few years but that there should be a further
10 expansion of this program in dental health education,
11 dental examinations of children, and the treatment of
12 dental indigents.

13 12. THAT with the admitted magnitude of
14 the problem of dental disease, Dental Public Health does
15 not at present receive a fair share of the Health Budget.

16 13. THAT treatment facilities for the
17 handicapped are not properly organized and should receive
18 greater attention of a specialized nature.

19 14. THAT the problem of providing compre-
20 hensive treatment for the group of low income people who
21 are not on social allowances and are unable to assume the
22 responsibility of extra financial commitments for dentistry,
23 is a very real and pressing one for which some solution
24 must be found.

25 15. THAT the only School Dental Service
26 at a municipal level is in the City of Winnipeg and it
27 is felt that this should be expanded at the municipal or
28 school division level wherever possible to include dental
29 health education and examination of pre-school and Grade I
30 children and comprehensive treatment for children who are
dental indigents.

16. THAT the dental service in hospitals

1. The first of these is the fact that the dental service is not a self-sufficient unit, but is dependent on the general medical service for many of its requirements.

2. The second is the fact that the dental service is not a self-sufficient unit, but is dependent on the general medical service for many of its requirements.

3. The third is the fact that the dental service is not a self-sufficient unit, but is dependent on the general medical service for many of its requirements.

4. The fourth is the fact that the dental service is not a self-sufficient unit, but is dependent on the general medical service for many of its requirements.

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6. The sixth is the fact that the dental service is not a self-sufficient unit, but is dependent on the general medical service for many of its requirements.

7. The seventh is the fact that the dental service is not a self-sufficient unit, but is dependent on the general medical service for many of its requirements.

8. The eighth is the fact that the dental service is not a self-sufficient unit, but is dependent on the general medical service for many of its requirements.



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3 is now confined to dental surgery and in our opinion it
4 is wrong to provide no alternative but extractions to
5 those eligible to attend hospital Out-Patient clinics.

6 17. THAT the Medicare scheme of the
7 Provincial Government seems to provide the necessary
8 treatment for those eligible, although the usage is only
9 18.8 percent. It is obvious that the plan will not
10 contribute greatly to raising the overall level of dental
11 health of this group without greater usage.

12 18. THAT the creation of a Faculty of
13 Dentistry in the University of Manitoba has been a good
14 thing for the profession and will have a great influence
15 on its ability to better serve the public. If at least
16 one more school were created in the western provinces
17 and the entire graduating class of our school were
18 available to the profession in this province, the number
19 of dentists in Manitoba would soon be sufficient to meet
20 the present demand for dental treatment.

21 19. THAT the per capita population consu-
22 ming fluoridated communal water supplies is the highest
23 in Manitoba of any province in Canada. The City of
24 Brandon is being used as a control by the Department of
25 Health of the province for regular surveys carried out
26 in the approved manner. This investigation is showing
27 that the results from the consumption of fluoridated
28 water supplies are as beneficial to dental health here
29 as has been found in other places.

30 20. THAT the Manitoba Denture Clinic,
created as an experiment by the Manitoba Dental Associa-
tion, is providing help in the prosthetic field to



those who are in the hospital dental clinics.
It is felt that the future scheme of the
Provincial Government seems to provide the necessary
treatment for those eligible, although the usage is only
18.6 percent. It is obvious that the plan will not
contribute greatly to raising the overall level of dental
health of this group without greater usage.
18. What the location of a faculty of
dentistry in the University of Manitoba has been a good
thing for the profession and will have a great influence
on the ability to better serve the public. It is at least
one more school was needed in the western provinces
and the entire graduating class of our school was
of dentists in Manitoba would soon be sufficient to meet
the present demand for dental treatment.
19. That the per capita population con-
suming fluoridated natural water is the highest
in Manitoba of any province in Canada. The City of
Brandon is being used as a control by the Department of
Health. This investigation is showing
that the results show a consumption of fluoridated
water which has no beneficial to dental health here
as has been found in other areas.
20. That the Manitoba Dental Clinic,
is providing help in the practice field to



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3 certain segments of the population. The operation of
4 the clinic to date shows that at the fees presently
5 charged a financial loss is incurred.

6 21. THAT the Children's Dental Health
7 Week campaigns, carried out by the Dental Section of the
8 Provincial Department of Health and the Manitoba Dental
9 Association, in order to create awareness of the prevailing
10 conditions with regard to dental disease and to promote
11 dental health education, have been worthwhile.

12 22. THAT the Mediation Committee of the
13 Manitoba Dental Association, which was created for the
14 benefit of the public and the profession, has been
15 successful in this province.

16 RECOMMENDATIONS

17 As a result of our investigations in
18 connection with the brief and our evaluation of the
19 present overall dental situation, it is recommended that:

20 1. There is a great need for increased
21 emphasis on dental health education.

22 2. Steps be taken to increase the number
23 of dentists to meet the present demand.

24 3. Provision be made for a greatly
25 increased number of dentists, properly trained auxiliaries,
26 and greater facilities for treatment, before any plans
27 are put into operation to increase the present demand for
28 services or to provide tax-supported free comprehensive
29 service.

30 4. More dentists have training in
specialized fields and that some plan be instituted
whereby these specialists could be available for

of the dental profession in the province of Ontario.

The Provincial Department of Health and the Ontario Dental Association, in order to make a study of the dental facilities in the province and to make a report on the dental situation, have been working.

It is the intention of the Ontario Dental Association, which was created for the benefit of the public and the profession, has been successful in this province.

RECOMMENDATIONS

As a result of our investigations in connection with the brief and our evaluation of the present overall dental situation, it is recommended that:

1. There is a great need for increased

emphasis on dental health education.

2. Steps be taken to increase the number of dentists to meet the present demand.

3. Provision be made for a greatly

increased number of dentists, properly trained auxiliaries and greater facilities for treatment, before any plans are put into operation to increase the present demand for services or to provide tax-supported free comprehensive service.

4. Some dentists have training in specialized fields and that some plan be instituted whereby these specialists could be available for



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3 consultations at certain locations outside the metropoli-
4 tan area at regular intervals.

5 5. Training programs be instituted under
6 proper direction for chair assistants, hygienists, and
7 laboratory technicians.

8 6. The duties of dental auxiliaries be
9 expanded within the framework of the policy of the
10 Canadian Dental Association.

11 7. The work carried out under the Dental
12 Section of the Department of Health, and School Dental
13 Services which are under the direction of municipal
14 health authorities, be expanded to cover all pre-school
15 and Grade I children from the standpoint of dental health
16 education, preventive measures, and examinations. Treat-
17 ment should be confined to dental indigents of this
18 group, with treatment for other children being provided
19 in private offices under the normal patient-dentist
20 relationship.

21 8. The establishment of one or more
22 clinics for the treatment of the handicapped where
23 ordinary facilities are not adequate to handle the
24 situation.

25 9. The expansion of Out-Patient Depart-
26 ments of hospitals to carry out more comprehensive
27 treatment.

28 10. The benefits accruing from fluorida-
29 tion be emphasized at a national level and everything
30 possible be done to encourage the use of fluoridation
measures throughout the nation.

11. Children's Dental Health Week

consultations at certain locations outside the metropol-

itan areas at regular intervals.

5. Training programs be instituted under

proper direction for dental assistants, hygienists, and

6. The duties of dental auxiliaries be

expanded within the framework of the policy of the

Canadian Dental Association.

7. The work carried out under the Dental

Section of the Department of Health, and School Dental

Services which are under the direction of municipal

health authorities, be expanded to cover all pre-school

and Grade I children from the standpoint of dental health

education, preventive measures, and examinations. Treat-

ment should be confined to dental indigents of this

group, with treatment for other children being provided

in private offices under the normal patient-dentist

relationship.

8. The establishment of one or more

clinics for the treatment of the handicapped where

ordinary facilities are not adequate to handle the

situation.

9. The expansion of Out-Patient Depart-

ments of hospitals to carry out more comprehensive

10. The benefits accruing from fluorida-

tion be emphasized at a national level and everything

possible be done to encourage the use of fluoridation

measures throughout the nation.

11. Children's Dental Health Week



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3 campaigns be carried on at a national level.

4 12. The creation of prepayment plans to
5 cover dental treatment be encouraged.

6 THE CHAIRMAN: Thank you very much, Dr.
7 Cooke. Has anyone else with the group anything to add
8 at this time by way of explanation or comment?

9 COMMISSIONER GIRARD: In paragraph 8 on
10 page ii: "According to the best evaluation we are able
11 to make, the addition of 15 dentists outside the Metro-
12 politan Winnipeg area would fill all the suitable
locations".

13 In defining a suitable location, what are
14 the main factors that you would consider, and, secondly,
15 is the school population one of these factors?

16 DR. COOKE: The main factors that are
17 considered, Miss Girard, I believe are a little hard to
18 define from the standpoint that you can't always say what
19 people will do. However, the general experience has been
20 that a man will not go to a town to practise modern-day
21 dentistry unless in the first instance there are water-
22 works and sewage, and the experience has been among
23 those practising in the country in our province, and
24 people who supply with our materials and equipment and so
25 on, and try to find locations for men, and the Chambers
26 of Commerce and municipal health authorities who seek a
27 dentist, that a town must have a population of about
28 1,000 people. It must support and be the equivalent of a
29 town that would support two doctors, and have waterworks
30 and sewage and a hospital. This, we admit, and have
pointed out in a section of the brief, is a change from

cover dental treatment be encouraged.

THE CHAIRMAN: Thank you very much, Dr.

Cooke. Has anyone else with the group anything to add

at this time by way of explanation or comment?

COMMISSIONER GIRARD: In paragraph 8 on

page 11: "According to the best available we are able

to find that the population of the

locations".

In setting a suitable location, what are

the main factors that you would consider, and, secondly,

is the school population one of these factors?

DR. COOKE: The main factors that are

considered, Miss Girard, I believe are a little hard to

define from the standpoint that you can't always say what

people will do. However, the general experience has been

that a man will not go to a town to practice modern-day

dentistry unless in the first instance there are water-

works and sewage, and the experience has been among

those practicing in the country in the province, and

people who agree with our statistics and alignment and so

on, and try to find locations for new towns.

of Commerce and Municipal Health Authorities who seek a

dentist, that a town must have a population of about

1,000 people. It must supply and be the equivalent of a

town that would support two doctors, and have waterworks

and sewage and a hospital. This, we think, and have

pointed out in a section of the brief, is a change from



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4 20 or 30 years ago. We feel that transportation and
5 modern roads and so on have greatly influenced this
6 situation.

7 You have a map in the appendices of the
8 main section of the brief. There are two: Appendix 6
9 shows all the towns in Manitoba starting with the town
10 with the least population, which is a very small town,
11 and we have listed there the things that we feel are
12 required, and have shown where the dentists are. Then,
13 we have a map in Appendix 5 showing where the dentists
14 are with the populations of the areas that they are
15 serving, and there are areas in here where there are
16 great populations, which means a great number of school-
17 children, where there is greater scarcity of dental
18 attention or dental manpower than in other areas, and
19 this has something to do with towns where you can locate
20 a man.

21 COMMISSIONER STRACHAN: In paragraph 5
22 on page i you refer to the normal retirement age of
23 dentists practising in the Province, and that is verified
24 by records and pertains particularly to the City of
25 Winnipeg; yet in paragraph 18 on page iii you do state,
26 at the bottom of the page, the number of dentists in
27 Manitoba will soon be sufficient to meet the present
28 demand for dental treatment. Are you allowing for the
29 fact you can't look forward in the future to men of the
30 senior age who are practising now?

31 DR. COOKE: Yes, we are, sir. In the
32 brief we state it would take 85 dentists to replace the
33 men over 65 and to fill the present commitments of the

20 or 25 years ago. We feel that transportation and
situation.

You have a map in the appendixes of the
main section of the brief. There are two: Appendix 6
shows all the towns in Manitoba starting with the town
with the least population, which is a very small town,
and we have listed there the things that we feel are
needed, and have shown where the dentists are. Then
we have a map in Appendix 5 showing where the dentists
are with the populations of the areas that they are
serving, and there are areas in here where there are
great populations, which means a great number of school-
children, where there is greater scarcity of dental
attention or dental manpower than in other areas, and
this has something to do with towns where you can locate

A map

COMMISSIONER STRACHAN: In paragraph 5

on page 1 you refer to the normal retirement age of
dentists practising in the Province, and that is verified
by records and pertains particularly to the City of
Winnipeg; yet in paragraph 18 on page 11, you do state,
at the bottom of the page, the number of dentists in
Manitoba will soon be sufficient to meet the present
demand for dental treatment. Are you allowing for the
fact you can't look forward in the future to men of the
same age who are practising now?

EX. COOKE: Yes, we are, sir. In the

brief we state it would take 85 dentists to replace the
men over 55 and to fill the present commitments of the



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3 school program in Winnipeg and Dr. Connor in the Depart-
4 ment of Health. We only have a total of so few dentists
5 that it really would not take too many to fill the gaps
6 created by the retirement and death of the older men,
7 if we had the class of 30 in the school available this
8 year.

9 COMMISSIONER STRACHAN: Of course, you
10 can only depend on a certain percentage of that class
11 remaining in the province?

12 DR. COOKE: This is true.

13 COMMISSIONER STRACHAN: In paragraph 15
14 you refer to the School Dental Service -- reference is
15 made to the School Dental Service in the City of Winnipeg:
16 how extensive is that service?

17 DR. COOKE: May I ask Dr. McCormick to
18 answer this, Mr. Chairman?
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second program in Winnipeg and Dr. Johnson in the Depart-

that it probably would not take too many to fill the gaps
created by the retirement and death of the older men,

it we had the class of 30 in the school available this
year.

COMMISSIONER STRACHAN: Of course, you

can only depend on a certain percentage of that class

remaining in the province?

COMMISSIONER STRACHAN: In paragraph 10

you refer to the School Dental Service -- reference is

made to the School Dental Service in the city of Winnipeg;

how extensive is that service?

DR. COOK: May I ask Dr. McCracken to

answer this, Mr. Chairman?



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DR. McCORMICK: The City of Winnipeg operates a dental treatment service primarily for social welfare people, children rather, up to and including the age of 16 years. Our next group includes emergency treatment service for all children in the city school system up to and including the 16-year group. There is no economic barrier, if the child is not able to receive the services of their own private dentist at this particular time we will attend to their teeth. This particular program is established to relieve pain and infection that originates in the school system immediately or as soon as possible. Following this we treat an indigent group of patients, the pre-school children and the Grade I children. We extend these services on a basis that these families will co-operate. We recall these patients on a six to eight-month basis and I want to be clear on this point that if we find they co-operate then we treat them on a recall basis. This has proved to be very satisfactory.

THE CHAIRMAN: Does this cover all the schoolchildren in Winnipeg?

DR. McCORMICK: All the schoolchildren in the City of Winnipeg.

COMMISSIONER McCUTCHEON: Distinguishing between the City of Winnipeg and the metropolitan area?

DR. McCORMICK: Yes, the city proper.

DR. COOKE: We must clarify that, the program cannot be carried out because we have not got the personnel.

THE CHAIRMAN: All right.

DR. McCORMICK: We have a dental education



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3 program in operation again limited due to funds and
4 staff available. We attempt to utilize a school inspec-
5 tion system in kindergarten, Grade I and Grade 2. At
6 the time the dental team is visiting the school for
7 classroom inspection they notify the parents of any teeth
8 defects and recommend their own family dentist. From
9 there the dentist will give a short talk on oral hygiene.
10 We also supply models of upper and lower dentation in
11 plaster and a model of the six-year molars for the teacher.
12 Those are demonstrated to the children and used by the
13 teachers in order to promote dental education. However,
14 this is the limit we have at the present time.

15 COMMISSIONER STRACHAN: In paragraph 6 on
16 page 1 you mention that you do not have enough, a suffi-
17 cient number of orthodontists and other specialists. Do
18 you foresee any future post-graduate training in the local
19 school or what is being done or what you would hope will
20 be done?

21 DR. COOKE: I do not think that we are
22 competent to answer the first part of Dr. Strachan's
23 question. We naturally hope, as a matter of fact we
24 think this is an urgent problem, that there will be more
25 post-graduate training and more men trained with some
26 post-graduate training who do not confine the practice to
27 specialties. We hope these men will appear in the ranks
28 of the profession and we think this is an urgent matter.

29 COMMISSIONER STRACHAN: It would be fair
30 to put it this way: will the Manitoba Dental Association
be urging establishment of such post-graduate courses?

DR. COOKE: That is right, sir.

program in operation again limited due to funds and staff available. We attempt to utilize a school inspector the time the dental team is visiting the school for classroom inspection they notify the parents of any teeth defects and recommend their own family dentist. From there the dentist will give a short talk on oral hygiene. We also supply models of upper and lower dentition in plaster and a model of the six-year molars for the teachers in order to promote dental education. However, this is the limit we have at the present time.

COMMISSIONER: In paragraph 5 on page 1 you mention that you do not have enough, a sufficient number of orthodontists and other specialists. Do you foresee any future post-graduate training in the local school or what is being done so what you would hope will be done?

DR. COOPER: I do not know what we are competent to answer the first part of Dr. Stenmark's question. We naturally hope, as a matter of fact we think this is an urgent problem, that there will be more post-graduate training and more men trained with some specialties. We hope there will appear in the ranks of the profession and we think this is an urgent matter.

COMMISSIONER: It would be to put it this way with the American Dental Association be urging establishment of such post-graduate courses? DR. COOPER: That is correct, sir.



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4 COMMISSIONER STRACHAN: In paragraph 10
5 you say there should be proper organization and standards
6 of qualification and training set up for laboratory tech-
7 nicians and chair assistants. Who do you visualize as
8 doing this?

9 DR. COOKE: The policy we believe in in
10 connection with this, I probably should state that we in
11 this province have been perhaps the most anxious of any
12 of the provinces to have some extension of auxiliary
13 services and training and the policy that we believe in
14 was partly stated by Dr. Neilson previous to our submis-
15 sion. While the laboratory technician or the chair
16 assistant could not be expected to have the entry require-
17 ments to enter the dental school as a student, it is our
18 opinion and we feel that this training must be carried
19 on under the direction of the professional training body
20 whether the training be given in a technical institute or
21 by some other organization. We feel the professional
22 training body must have some control over it, control of
23 curriculum, control of qualifications and control of
24 whether the people have accomplished what they set out to
25 do. Therefore, we would like to see the school have the
26 control regardless of where the training is provided.
27 This has been carried out with our chair assistants which
28 has only been started since we got the school but they
29 have the facilities of the school and members of the
30 profession most of whom while they are practising dentists
are part-time men on the Faculty of Dentistry and they are
giving a course using the facilities of the dental school.
The Manitoba Dental Association certifies it. We feel

CONFIDENTIAL - WHAT IS IN paragraph 10

you say there should be a good organization and standards of quality, and then we see the laboratory tech-

doing this?

Dr. Colman: The policy we believe in is

connection with this, I probably should state that we in this province have been perhaps the most anxious of any

of the provinces to have some extension of auxiliary

services and training and the policy that we believe in was partly stated by Dr. Neilson previous to our submis-

sion. While the laboratory technician or the chair

assistant could not be expected to have the early require-

ments to enter the dental school as a student, in our

opinion and we feel that this training must be carried

on under the direction of the professional training body

whether the training be given in a technical institute or

by some other organization, we feel the professional

training body must have some control over it, control of

curriculum, control of qualifications and control of

whether the people have accomplished what they set out to

do. Therefore, we would like to see the school have the

control regardless of where the training is provided.

This has been worked out with our chair assistants which

has only been started since we got the school but they

have the facilities of the school and members of the

profession most of whom think they are practicing dentists

are working men on the faculty of dentistry and they are

giving a course using the facilities of the dental school.

The Manitoba Dental Association oversees it, we feel



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3 this should apply to the laboratory technicians too. I
4 might state that such a program for laboratory technicians
5 has already been considered.

6 COMMISSIONER STRACHAN: How long have you
7 had the nurses' class?

8 DR. COOKE: They are in the third class.

9 COMMISSIONER STRACHAN: Do they seem to be
10 staying with the dentists longer than normal since they
11 have been trained?

12 DR. COOKE: We do know, Mr. Chairman, that
13 the girls who have had training have been upgraded in
14 their positions to a certain extent. I think this makes
15 a natural conclusion that these girls then have something
16 and it has happened that some of them go and get married
17 but they do come back to these positions afterwards.
18 There is always a need for dental assistants and naturally
19 a girl who has had the course and is willing to go back
20 to work is more sought after than previously when we had
21 to go and get an untrained girl from school to do the
22 work. This definitely gives them some status.

23 COMMISSIONER STRACHAN: Referring to page 7,
24 paragraph 9, what is the present situation regarding
25 dental treatment in hospitals in the province?

26 DR. COOKE: The present situation in the
27 hospitals is laid out in Appendix 10. The teaching hospi-
28 tals have large dental staffs connected as part of the
29 medical service or the surgical service of the hospital
30 with a department division head. The two teaching hospi-
tals, St. Boniface General and Winnipeg General, each have
a staff of 10 dentists and they have large out-patient



1 this should apply to the laboratory technicians too. I
2 might state that such a program for laboratory technicians
3 has already been considered.
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5 COMMISSIONER STACHURA: Now how have you
6 had the success I mentioned?
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8 MR. COOPER: They are in the third class.
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10 COMMISSIONER STACHURA: Do they seem to be
11 staying with the dentists longer than normal since they
12 have been trained?
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14 MR. COOPER: We do know, Mr. Chairman, that
15 the girls who have had training have been regarded as
16 their positions to a certain extent. I think this makes
17 a natural conclusion that these girls then have something
18 and it has happened that some of them go and get married
19 but they do come back to these positions afterwards.
20 There is always a need for dental assistants and naturally
21 a girl who has had the course and is willing to go back
22 to work is more sought after than previously when we had
23 to go and get an untrained girl from school to do the
24 work. This definitely gives them some status.
25
26 COMMISSIONER STACHURA: Referring to page 7,
27 paragraph 2, what is the present situation regarding
28 dental treatment in hospitals in the province?
29
30 MR. COOPER: The present situation in the
31 hospital is set out in Appendix B. The dental hospital
32 has have large dental units connected as part of the
33 medical service on the surgical service of the hospital
34 with a department division head. The two teaching hospitals,
35 St. Boniface General and Winnipeg General, each have
36 a staff of 10 dentists and they have large out-patient



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4 departments. The people who go to the out-patient depart-
5 ments receive surgical dental treatment on the same basis
6 as anybody else attending out-patient departments would
7 receive in medical treatment. The dental treatment in the
8 out-patient department is confined to this surgical-dental
9 treatment and this is the only dental treatment provided
10 in the hospitals on an out-patient basis. Now, all the
11 hospitals in Winnipeg have some kind of dental staff.
12 The courtesy staff in the hospitals confine themselves
13 to treatment of their own private patients so it is in
14 reality St. Boniface General and Winnipeg General where
15 you have the large staffs. At the Children's Hospital
16 it is confined, as the name implies, to children and they
17 also have a large staff. In this hospital in the past
18 they have carried out some more comprehensive treatment
19 than the surgical treatment but at the moment this is not
20 any large operation, in fact, it is such a small operation
21 that we ignore it.

22 COMMISSIONER STRACHAN: Thank you. Now,
23 referring to the treatment of handicapped children, you
24 say in paragraph 8 on page 6:

25 "The establishment of one or more clinics
26 for the treatment of the handicapped
27 where ordinary facilities are not adequate
28 to handle the situation".

29 I would take it that such clinics would
30 have to be established in hospitals?

31 DR. COOKE: As a matter of fact in the
32 brief we say there are two types of these clinics we
33 would like to see. As most people are aware the group of



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4 people we call the handicapped now are not necessarily
5 only the group we know as retarded children; there are
6 a lot of other people who grow to adulthood who have
7 various things like multiple sclerosis and various other
8 diseases which makes it almost impossible for them to
9 attend a private dental office and receive treatment in
10 the regular manner. Then, there are a number of groups
11 such as the retarded children who reach teen-age and
12 adulthood as well as children themselves. This group,
13 when they are children, cannot be handled in the ordinary
14 manner in a dental office. We have nowhere in this
15 province available to either these people or the profes-
16 sion the two things that are necessary for these cases;
17 number 1, we feel there must be men with special training
18 to handle these cases because they are not cases that a
19 dentist is ordinarily taught to handle. Number 2, if a
20 general anaesthetic is needed it is felt by everybody
21 involved that a general anaesthetic carried out as in the
22 present circumstances should be carried out in a hospital
23 and with the proper facilities. Therefore, we feel there
24 should be set up close to the school, the Faculty of
25 Dentistry in either the Children's or the Winnipeg
26 General Hospital, a clinic where general anaesthetics
27 could be given to these children and the students could
28 participate on a basis of being taught how to handle these
29 cases. This clinic could be manned by people with some
30 special training over and above the training a dentist
ordinarily has.

Then, there is another classification
involved here of people who have some handicap and cannot



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4 be handled adequately in an ordinary dental office but
5 are not emotionally disturbed or physically handicapped
6 to the point where they need general anaesthetic. There-
7 fore, we feel there should be a second classification
8 in these clinics and that is a clinic where an ordinary
9 dental treatment could be carried out for these people
10 in such places as the School for Retarded Children or
11 every school for retarded children.

12 COMMISSIONER STRACHAN: Thank you. You
13 have done exactly what I hoped you would do and I was
14 sure you would do. You put on record to this Commission
15 the fact that there are certain individuals in our
16 society who cannot be treated suitably or adequately in
17 a proper dental office and you certainly explained that
18 very clearly. I would address this question to Dr.
19 Connor: would you explain to this Commission your function
20 in the department and do you do any clinical dentistry
21 at all?

22 DR. CONNOR: Mr. Chairman, we in the
23 department have been attempting to organize in this
24 province a comprehensive dental public health program.
25 We have found from our dental health index which you
26 have as an appendix the general condition of children in
27 this province and the condition that attacks 95% of our
28 population where we have 40% of our children completely
29 neglected, 24% receiving probably extraction and another
30 20% with some fairly adequate repair and only 16%
receiving good care. This is a major public health
problem and we are taking it on that point. We base our
whole thesis on our planned program which has been



be handled adequately in an ordinary dental office but

There-

in these clinics and that in a clinic where an ordinary dental treatment could be carried out for these people in such places as the Federal Government Children or every school that reported on them.

COMMISSIONER STANLEY: Thank you, you

have done exactly what I hoped you would do and I was sure you would do it. You put me word to this Commission the fact that there are certain individuals in our society who cannot be treated entirely or adequately in a proper dental office and you certainly explained that very clearly. I would address this question to Dr.

Conner would you explain to this Commission your function in the department and do you do any clinical activities

DR. CONNER: Yes, sir, in the

department have been a tendency to organize in this province a comprehensive dental public health program.

We have found that our dental public health work which you have as an appendix to the report of children in this province and the condition that involves 95% of our population wants to have 100% of our children completely neglected, 10% neglected, 10% neglected and another 80% with some dental activity, perhaps only 10%.

receiving good care. That is a major public health problem and we are talking in our report. We have our whole efforts on our dental program which has been



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3 presented to the Minister of Health and which has been
4 accepted in principle on dental health education. That
5 is our prime and most important field of endeavour. I
6 will not go into detail on this but we have this set-up
7 with a trained public health dentist in each area. We
8 do plan in this program to supply a certain type of
9 limited care, care for pre-school children up to the
10 age of 6 through our presently organized health unit
11 programs. In this province we have other difficulties,
12 geography and location, dentists practising in rural
13 Manitoba. We are presently carrying out a program whereby
14 we do provide care to communities where there is no care:
15 or, if there is care, it is quite inadequate. This will
16 have to be done and continue to be done.

16 We also plan in our proposed plan to
17 provide care for a certain selected type, selected
18 actually by our public health nurses of dentally indigent
19 patients. As you know, the indigent is a person receiving
20 social allowances or welfare under our present Medicare
21 plan but we feel we have to go beyond that to a small
22 group who are not eligible for social allowances but who
23 have very great difficulty in looking after themselves.
24 This will be a select group.

24 This is our main thesis and plan; dental
25 health education first with the care for pre-school up to
26 6 years of age; supplying care for outlying areas and for
27 the dentally indigent but to a very small degree.

27 COMMISSIONER STRACHAN: Mr. Chairman, this
28 is not a question but I would like to refer to Appendix 9
29 and draw attention to the fact under paragraph 3, the
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4 righthand side of the page, where an estimate has been
5 made on the basis of annual increase in the school popula-
6 tion with allowance made for 60% reduction of the dental
7 workload due to the continued use of fluoridated communal
8 water supply. I think this is a remarkable demonstration
9 of the faith and confidence, in fact, I think there is a
10 better word to use, of the knowledge of what fluoridated
11 communal water supply will do in the reduction of dental
12 conditions.

13 COMMISSIONER GIRARD: I had two questions
14 but I believe Dr. Connor has just answered one of them.
15 The other one is, what use is being made in the province
16 with the help of the public health nurse in bringing in
17 the dissemination of dental health information? I
18 believe you answered that. Did you have anything further
19 on that? I am thinking of your campaign, your dental
20 week campaign and things like that.



G/dpw

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4 DR. CONNOR: Yes, we do use our public
5 health nurses. They are a very, very important group.
6 We feel we have two vitally important groups, the public
7 health nurse and the schoolteacher. It is our plan to
8 take our program, integrated as part of the health program
9 across the province, and public health nurses will be
10 vital for dental health education and home education and
11 the various activities they carry on. They are a very
12 important group as far as we are concerned.

13 COMMISSIONER GIRARD: The other question
14 was again pertaining to dental health information, there
15 was another source that I was thinking of. Are there
16 any schools of nursing where the dental health courses,
17 or oral hygiene courses are given by dentists? I am
18 talking about the basic, three-year courses for nurses.
19 I know that this is done in certain places, and I was
20 wondering if it is done with a lot of benefit for the
21 nurses?

22 DR. COOKE: We made a short statement
23 about this, the duties that a hospital dental staff
24 should have, and we think that this is carried out in a
25 very inadequate manner at this time, both the dissemina-
26 tion of knowledge to the nursing schools and the dissemina-
27 tion of dental health knowledge to the practising physician,
28 and this may be more important in this province than in
29 some others, because of our rural set-up, and our diffi-
30 culty in the number of very small towns that we have, and
31 the fact that both nurses and doctors in many of these
32 places have to do a lot of emergency dental treatment,
33 but we think that our program at present is most



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3 inadequate.

4 COMMISSIONER GIRARD: Is this being done
5 at present?

6 DR. COOKE: Well, I say the program, we
7 feel, is most inadequate. There is a little, we cannot
8 say there is nothing being done, but it is an inadequate
9 program.

10 COMMISSIONER VAN WART: Dr. Cooke, you
11 told us about the out-patient dental service in the
12 hospitals. Is there any in-patient dental service in
13 the hospitals?

14 DR. COOKE: The active dental staff of the
15 hospital carry out in-patient consultation services the
16 same as any other group in the hospital, with the one
17 limitation which we are raising such a strong objection
18 to in the brief, that this is limited strictly to surgical
19 procedures.

20 COMMISSIONER VAN WART: Have the dentists
21 the right to admit patients to the hospital under their
22 own care?

23 DR. COOKE: We have in this province sir.
24 We are very proud of this fact. We have a very good
25 understanding with the Blue Cross, which created our
26 first entry into the hospitals and when the national
27 hospitalization scheme came into effect, the Minister of
28 Health at that time and his Department agreed to accept
29 the arrangement we had had under Blue Cross in toto, due
30 to the fact that this had been such a good experience.
This is one thing we are very proud of in this province,
the dentist admits his own patients, and all the hospitals

COMMISSIONER VAN WART: Is this being done

at present?

DR. COOK: Well, I say the program, we

feel, is most inadequate. There is a little, we cannot

COMMISSIONER VAN WART: Dr. Cook, you

told us about the out-patient dental service in the

the hospitals?

DR. COOK: The active dental staff of the

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first emergency dental hospitals and with the National

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to the fact that this had been such a good experience.

This is one thing we are very proud of in this province.

The dentist admits his own patients, and all the hospitals



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4 accept that, and I am not sure that this has not been
5 remedied, one hospital in the province wouldn't accept it,
6 but I think that was a matter of personalities.

7 COMMISSIONER VAN WART: Do you have diff-
8 culty in getting admissions?

9 DR. COOKE: No, we do not sir. In the
10 hospitals in the city this has been going on long enough
11 now that there are in each hospital a certain number of
12 beds, and this is usually associated with E.N.T., and
13 there are a certain number of beds available, and if you
14 can tie in the use of the E.N.T. section of the operating
15 room and the vacant bed, you are home free, and there is
16 no trouble.

17 COMMISSIONER VAN WART: The crowded bed
18 situation does not affect you then?

19 DR. COOKE: No, because the beds are
20 limited to this ward, you see. We have a ward in our
21 hospital that I am connected with, where only E.N.T. and
22 dental cases go. The rest of the hospital might be full,
23 but we might still have an empty bed there. I might add
24 too, that in dental cases there is a greater turnover,
25 so that bed usage does not go on too long.

26 COMMISSIONER STRACHAN: What do you
27 consider the normal usage of a bed for a dental patient?

28 DR. COOKE: Mr. Chairman, we have in our
29 recommendations in the body of the brief made a statement
30 about this. The normal procedure which arose out of our
original arrangement with Blue Cross, who agreed at the
time to provide two days' hospitalization for dental
cases, more days if necessary, providing there was a

report that, and I am not sure that this has not been

COMMISSIONER VAN WART: As you have diff-

DR. COCKE: No, we do not stir. In the

hospital in the city that has been going on long enough

now that there are in each hospital a certain number of

beds, and this is usually associated with E.W.T., and

there are a certain number of beds available, and if you

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so that bed usage does not go on too long.

COMMISSIONER STEVENS: What do you

consider the normal usage of a bed for a dental patient?

recommendations in the body of the report made a statement

original arrangement with Blue Cross, who agreed at the

this to provide two days' hospitalization for dental

cases, more days if necessary, providing there was a



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3 medical reason certified by a physician. In other words,
4 the dentist had two days leeway on his cases. The pattern
5 that has evolved here is that all the dental cases spend
6 two days in the hospital if there are no extenuating
7 circumstances, when they spend further days on medical
8 certification. They have one further hospital in the
9 City of Winnipeg, the Grace Hospital started a procedure
10 with the co-operation of the anaesthetists, whereby
11 dental cases that do not require a long stay, in other
12 words, are routine extraction cases, can go in on an out-
13 patient basis in the morning, have a general anaesthetic,
14 spend the day in the recovery room, and be discharged in
15 the late afternoon, if everything is normal, and, as we
16 state in the body of the brief, we feel that this program
17 should be extended everywhere, because we feel the saving
18 in beds and costs is about 50%, but we have not been able
19 to get this instituted in other hospitals. This is the
20 one and only program as, if you will refer to the appendix,
21 you will see is being used.

22 THE CHAIRMAN: Dr. Cooke, if I may go to
23 another subject. As you know, there is talk of an overall
24 health services plan that may, or that might, include
25 dentistry as one of the services to be included in the
26 overall program, and it has been suggested that so far as
27 Manitoba is concerned, that the Manitoba medical scheme
28 would be the vehicle that might administer such a program.
29 Would the Dental Association be satisfied in the event of
30 such an overall program to have the administration done
by Manitoba Medical?

DR. COOKE: Mr. Chairman, it is going to be



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3 difficult to be brief on this.

4 THE CHAIRMAN: You can appreciate there
5 must be some administrative body to administer the kind
6 of a program that has been discussed, or recommended?

7 DR. COOKE: Mr. Chairman, the answer is
8 no, but I don't like to just say no like this without
9 any further extension of this. When I referred a few
10 moments ago to Blue Cross granting us admission privileges
11 to the hospitals this was along exactly the same lines.
12 As a matter of fact, we tried it the other way to start
13 with. We made arrangements with Blue Cross, and we had
14 a form which was signed, whereby we got our admissions
15 through a medical man, and Blue Cross, not the Dental
16 Association, but Blue Cross were the first to ask us to
17 have this changed. There are some differences between
18 medicine and dentistry.

19 THE CHAIRMAN: Well now, I am not talking
20 about hospital admissions.

21 DR. COOKE: No, but the differences between
22 medicine and dentistry come in there sir, as they do in
23 the ordinary practice of dentistry, and I am sure that
24 we would object very strenuously to not having control of
25 our own administration.

26 THE CHAIRMAN: Do you mean that you would
27 want a separate body to administer any money that would
28 be made available for the extension of dental work, either
29 universally or to all those who would like to come in under
30 a program?

31 DR. COOKE: No, I don't think that if the
32 proper arrangements were made for us to participate, sir,



difficult to do that.

THE CHAIRMAN: I am appreciative there

must be a body to administer the kind

of a program that has been discussed or recommended?

DR. COOPER: In California, the answer is

no, but I think that is not the case with most

any further extension of this. When I received a few

months ago to discuss the problem of administering the

to the hospital and was along exactly the same lines.

As a matter of fact, we tried in the other way to start

with. We made arrangements with one group, and we had

a form which was not, what we got out of this

through a meeting and the other, not the best.

Association, but the other was the first to ask us to

have this changed. There are some differences between

medicine and dentistry.

THE CHAIRMAN: Well now, I am not talking

about hospital administration.

DR. COOPER: No, but the differences between

medicine and dentistry come in these six, as they do in

the ordinary practice of dentistry, and I am sure that

we would object to a situation in which having control of

our own education.

THE CHAIRMAN: Do you mean that you would

want a separate body to administer any money that would

be made available for the extension of dental work, either

universally or in some way would like to come in under

a program?

DR. COOPER: No, I don't think that is the

proper arrangement. There is no one to participate, sir.



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3 that there would be any objection:

4 THE CHAIRMAN: Naturally you would ask for
5 representation I suppose?

6 DR. COOKE: Right sir, right.

7 COMMISSIONER FIRESTONE: Dr. Cooke, why
8 have you not been able to persuade other hospitals to
9 use the out-patient approach in the case of light dental
10 surgery, as you have recommended?

11 DR. COOKE: I think, Mr. Chairman, this
12 strictly is a matter of routine and procedures, and so
13 on. The set-up in the out-patient department has not
14 been one which fitted in with this kind of operation
15 without major changes, which we have not been able to get.

16 COMMISSIONER FIRESTONE: Are these other
17 hospitals not interested in saving hospital days?

18 DR. COOKE: I wouldn't say that sir. I
19 think it is a case of the employment of rooms and facili-
20 ties.

21 THE CHAIRMAN: We heard from the anaesthe-
22 tists yesterday afternoon that they were anxious for this
23 kind of thing.

24 DR. COOKE: Yes, but the anaesthetists
25 within hospitals I think, and facilities.

26 THE CHAIRMAN: Yes, they did say that
27 facilities would be required.

28 COMMISSIONER FIRESTONE: Have you any
29 specific suggestions to make as to the kind of additional
30 facilities that would be required to make it possible to
implement the program you are recommending?

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31 DR. COOKE: I suppose, sir, that money is



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3 the basic thing involved here, and the amount of space
4 available, and so on. In my own hospital they have a
5 certain section of the hospital for casualty treatment
6 on this basis, and I just think that there is no more
7 room at the moment for us to set up this kind of program.
8 It would require more space and probably more staff than
9 is available.

10 COMMISSIONER STRACHAN: In other words,
11 you would need a room, or at least a couch or bed for a
12 patient for a whole day?

13 DR. COOKE: It is not the fact, you see
14 in the case of emergency I could take one patient in and
15 do this, sir, but if we had 50 cases there in one day,
16 as Dr. Strachan pointed out you need 50 recovery beds.

17 THE CHAIRMAN: What is your accommodation
18 there now? You say in this section you have some beds.
19 50 is a big space in a hospital to me.

20 DR. COOKE: I am talking about the casualty
21 section.

22 THE CHAIRMAN: I want to relate it to the
23 space you said you had available in the hospital to you a
24 while ago.

25 DR. COOKE: We do not use that section at
26 the moment, sir, in my hospital. We don't use the
27 casualty section at all.

28 THE CHAIRMAN: I am not talking about the
29 casualty section. You told us a while ago you were able
30 to get admissions, you were not too concerned about the
fact that there was a shortage of hospital beds because
a section was allocated to you. How many beds?



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3 DR. COOKE: I don't know, but this is a
4 big ward in the hospital, which handles all the ear, nose
5 and dental cases.

6 THE CHAIRMAN: Surely you are able to tell
7 me how many beds there are in that ward?

8 DR. COOKE: There must be 50 sir.

9 THE CHAIRMAN: That is for the other
10 services as well?

11 DR. COOKE: Yes.

12 COMMISSIONER STRACHAN: I think, Mr.
13 Chairman, what Dr. Cooke is pointing out is that there
14 is no accommodation for any number in the out-patient
15 department.

16 DR. COOKE: This is the point.

17 THE CHAIRMAN: No, but he wouldn't want
18 any greater accommodation in the out-patient department
19 than he got now, which he is satisfied with.

20 DR. COOKE: Sir, we are using the other
21 set-up, where a patient goes to the operating room and
22 goes back to the ward, and stays. This is in a different
23 section of the hospital than the casualty ward, where a
24 patient could come in under certain emergency circum-
25 stances and have an anaesthetic.

26 THE CHAIRMAN: I understood that the first
27 time.

28 COMMISSIONER FIRESTONE: Dr. Cooke, may
29 we turn to paragraph 179 on page 38, in which you say
30 that the dental profession in Manitoba supports a principle
of prepayment for dental care under a plan organized on a
sound basis. Have you any suggestions yourself what such

big ward in the hospital, which handles all the cases, and general cases.

THE CHAIRMAN: Surely you are able to tell

me how many beds there are in that ward?

MR. COOPER: There must be 30 beds.

THE CHAIRMAN: I am sorry that I cannot see the point of this question. I am sure that you are able to tell me how many beds there are in that ward.

MR. COOPER: This is the point.

THE CHAIRMAN: No, but we wouldn't want

any other accommodation in the out-patient department.

than we got now, which he is satisfied with.

MR. COOPER: Sir, we are using the other

beds, when a patient goes to the operating room and

goes back to the ward, and stays. This is in a different

section of the hospital than the casualty ward, where a

patient could come in under certain emergency circumstances

and have an operation.

THE CHAIRMAN: I understand that the first

we turn to paragraph 178 on page 20, in which you say

that the general provision in Manitoba respects a principle

which bears the name of the person who was



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3 a plan would be on a sound basis?

4 DR. COOKE: No I haven't sir.

5 COMMISSIONER FIRESTONE: Would it be
6 possible for the Manitoba Dental Association to give
7 further consideration of what such a plan would be, what
8 would be a sound plan, and could such information be
9 made available to us in writing at a subsequent date?
10 You will appreciate, Dr. Cooke, that if the Commission is
11 to make recommendations, it requires the advice of the
12 people that know something about the subject, and we
13 presume the Manitoba Dental Association is familiar with
14 the problem, and that we can have your advice. Would it
15 be possible as a result of subsequent consideration to
16 come forward with a complete proposal? As you know, the
17 Manitoba Medical Association has come forward with a
18 proposal. We like to take account of your views. Would
19 it be possible to do this at a later date, and let us
20 have it in writing?

21 DR. COOKE: Yes.

22 COMMISSIONER FIRESTONE: And in submitting
23 such a proposal, could you take account of one specific
24 question, which I will read into the record, and for
25 which you can give us an answer subsequently in writing,
26 and give your consideration to it. Would the Manitoba
27 Dental Association be in favour of a national plan of
28 prepaid dental care which takes into account, (1) payment
29 to this plan by those that can afford it, (2) Government
30 subsidies for those that cannot afford it, (3) participa-
tion by the Government of Manitoba, and (4) co-operation
with the dental profession in Manitoba?

17. COORD. No. 1 have a...

possible for the Manitoba Dental Association to give

further consideration of what such a plan would be, what

you will appreciate, Mr. Glick, that the Commission is

people that know something about the subject, and we

through the Manitoba Dental Association is familiar with

the problem, and that we can have some advice, would it

be possible as a result of your consideration to

come forward with a concrete proposal, as you know, the

Manitoba Dental Association has come forward with a

proposal. We like to take account of your views, would

it be possible to do this in a later session, and if we

have it in writing?

MR. Glick: Yes.

COMMISSIONER: All right. And in summarizing

such a proposal, could you take account of the specific

proposal, which I will read into the record, and then

which you can give an answer, especially in writing,

and give your considerations to me. Would the Manitoba

Association be able to do this? The Commission is

proposed that it take account of these into account, (1) payment

to this plan by those that can afford it, (2) Government

action by the Government of Manitoba, and (3) co-operation

with the Dental Association in Manitoba.



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3 DR. COOKE: Yes sir.

4 COMMISSIONER FIRESTONE: Thank you very
5 much. And the last question sir. Would you be in favour
6 of a national scholarship plan for medical students,
7 including students entering the study of dentistry?

8 DR. COOKE: I am sure we would sir.

9 COMMISSIONER FIRESTONE: Would it be
10 possible in your subsequent written material with which
11 you may be supplying us to tell us a little about group
12 practice of dentistry in Manitoba, and some of the advan-
13 tages, both to the dentist practising in group practice,
14 and to the patient?

15 DR. COOKE: Yes sir.

16 THE CHAIRMAN: Dr. Cooke, on page 6 of
17 your conclusions and recommendations, item 10, you refer,
18 you say that the benefits accruing from fluoridation to
19 be emphasized on a national level, etc. Can you tell us,
20 is there any provincial contribution to that fluoridation
21 program at the present time?

22 DR. COOKE: Do you mean from the Provincial
23 Government sir?

24 THE CHAIRMAN: Yes.

25 DR. CONNOR: Mr. Chairman, yes there is.
26 As you have noted, fluoridation in Brandon has been our
27 centre of study of this program. This has been carefully
28 done on a pre-fluoridation survey, carefully carried out,
29 and done every year for five years by the same examiner,
30 under the same conditions, the same regulations of resi-
dence, and we have published, I think you have it in the
appendix of the Manitoba Government report on five years



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3 of fluoridation in Manitoba. This report I know supports
4 fluoridation. It has shown the really wonderful benefits of
5 this. The addition of a small part of fluoride to a
6 million parts of water, and we feel it is one of the
7 things that should be adopted, and I think the dental
8 group will say the same thing, as a measure across this
9 country. It is positive, inexpensive, and will do a
10 wonderful job for the people of this country.

11 THE CHAIRMAN: What is the provincial
12 contribution?

13 DR. CONNOR: There is no provincial contri-
14 bution, except for the carrying out of the work, that is
15 part of our job.

16 THE CHAIRMAN: With your staff?

17 DR. CONNOR: Yes.

18 COMMISSIONER McCUTCHEON: Is there moral
19 persuasion on the municipalities?

20 DR. COOKE: No, there is not sir. The
21 Greater Winnipeg Water System supplies the water for the
22 metropolitan area, and various groups interested got a
23 change in the Act to allow any municipality to do this
24 that wanted to under certain circumstances, and from then
25 on this is entirely up to the municipality, and they must
26 get permission from the Department of Health of the
27 province, and they carry this out at their own instigation
28 and under their own waterworks.

29 COMMISSIONER McCUTCHEON: But I assume from
30 the statement Dr. Connor made his Department would encour-
age the municipality to do this?

DR. CONNOR: Yes we do sir, we encourage



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3 this.

4 THE CHAIRMAN: Thank you very much Dr.
5 Jackson, Dr. Cooke and the others in your delegation
6 here this morning. You have given us a very good and
7 complete picture, and we are obliged to you for your
8 assistance. Thank you.

9 We will now adjourn until 2 o'clock.

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11 --- Luncheon adjournment.
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3 --- On resuming at 2.10 p.m.

4 THE CHAIRMAN: Ladies and gentlemen, we
5 will come to order and proceed with the submission of
6 the Manitoba Farmers' Union.

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8 SUBMISSION OF THE MANITOBA FARMERS' UNION

9 Appearances: Mrs. O. Aitken
10 Mrs. M. Oliver
11 Mrs. M. McIntosh

12 --- EXHIBIT NO. 61: Submission of the Manitoba Farmers'
13 Union.

14 MRS. AITKEN: Mr. Chairman, I have with me
15 today representing the Manitoba Farmers' Union Mrs. Mary
16 McIntosh, past women's President of the Manitoba Farmers'
17 Union and Mrs. Margaret Oliver, the women's Vice-President.
18 I am Mrs. Olive Aitken, the present women's President of
19 the Manitoba Farmers' Union.

20 With that, I think we will get into our
21 brief which you will see is rather short.

22 The Manitoba Farmers' Union, representing
23 19,000 direct dues-paying members, appreciates the oppor-
24 tunity of appearing before this Commission on Health
25 Services.

26 We have approximately 300 autonomous
27 Locals in our organization. The recommendations in this
28 presentation contain farm policy formulated through the
29 Farm Union organization. Discussion of resolutions is
30 first started on the Local level. Once approved, they go
on to the District Conventions in the ten respective Dis-
tricts. From there, the total resolutions are co-ordinated



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3 and presented to our Annual Provincial Convention for
4 final policy approval. So the views presented herein are
5 actually the viewpoint of a wide cross-section of farm
6 people in Manitoba.

7 The first consideration of any government
8 should be the welfare of its people. The highest standard
9 of health is the right of every individual.

10 That good medical care is available to the
11 people of this province goes without saying; but the fact
12 remains there are many people who are hesitant about
13 seeking medical care because of the high costs involved.
14 The Canadian Sickness Survey conducted by the Federal
15 Government in 1951 pointed this out quite clearly. The
16 lower income groups were found to have more illness and
17 more days of disability than did the high income groups.
18 On the other hand, however, the volume of medical care
19 received by the low income groups was much less than that
20 received by those in the higher income brackets.

21 Our basic industry in Manitoba (agricul-
22 ture) unfortunately falls into this lower income bracket
23 with many of our people being denied the opportunity of
24 adequate medical care because of the exorbitant costs of
25 diagnostic service, medical treatment and drugs.

26 The agricultural industry in our province
27 has been engulfed in a continuous rise in operating costs
28 over the past number of years, while income and prices
29 have generally declined.

30 To review briefly the actual conditions:
Cash Receipts from the sale of Farm Products in Manitoba
during the last two five-year periods of 1951-55 and



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3 1956-60, declined from \$111,707 million to \$108,696
4 million respectively. This loss of \$3,011 million
5 occurred in spite of a constant and heavy increase of
6 production and marketings of farm products.

7 During this same period, operating costs
8 and depreciation increased from \$678,816 million to
9 \$707,180 million, an increase of \$28,364 million.

10 As a result of this cost-price pressure,
11 farm net income during this period decreased from
12 \$593,053 million in the period 1951-55, to \$565,698
13 million for the period 1956-60, a loss of \$27,355 million.

14 Voluntary programs of medical protection
15 have not been readily available nor proven acceptable to
16 a large number of rural people. There are few rural
17 groups using the Manitoba Medical Service. Those people
18 who probably need coverage most are excluded from the
19 program because of the cost of such coverage. The
20 obvious conclusion is that while low income people may
21 receive minimal service, they are prevented by financial
22 reasons from receiving the degree of medical care that
23 is desirable for good health.

24 Since 1953, the MFU membership has been
25 on record as favoring a National Health Plan. Since
26 there has been little evidence of such a plan materializing,
27 not too much thought has been given by our members as to
28 the form a National Health Plan should take. As a
29 result, our recommendations here must be of a general
30 nature. At our recent Provincial Convention in December,
1961, the following resolution was approved:



NATIONAL HEALTH PLAN

Whereas our membership has indicated that they are in favor of a National Health Plan, and

Whereas a large majority of the people are unable to pay for adequate medical care with its rapidly increasing costs:

BE IT RESOLVED that we recommend a comprehensive medical care program with universal coverage of all residents in the province, and

BE IT FURTHER RESOLVED that any National Health Plan should be administered by the provinces and financed largely by Federal grants, coupled with personal premiums set at a level which can be met by all self-supporting persons.

Comprehensive medical care should cover those medical services necessary to maintain health, treat illness and disability. This would include prevention, diagnosis, medical and surgical treatment, and rehabilitation. We believe that, in financial planning, the Government should take into consideration the necessity for increased aid for the mentally ill, and also rehabilitation for this group. One important aspect of the rehabilitation is the education of the public to accept and assimilate these persons more gracefully into society.

In the case of retarded children, regardless of their age, provision should be made to assist the parents financially in the care (including drugs) and



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for increased aid for the mentally ill, and also rehabili-
tation for this group. One important aspect of the rehabili-
tation is the education of the public to accept and
assimilate these persons more graciously into society.

In the case of retarded children, regardless
of their physical condition, the State should



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3 education of these retarded children. Throughout the
4 country we see and hear of cases where such families are
5 dreadfully burdened. We believe that sheltered workshops
6 could be a tremendous asset both to the mentally ill and
7 for retarded children.

8 Across the province great concern is
9 expressed over the high cost of drugs. Under a comprehen-
10 sive health plan, any drugs prescribed by a physician,
11 and safe for use in the home, should be obtainable under
12 the Plan.

13 Special services, such as dental and eye
14 treatments, necessary for the maintenance of good health,
15 should also be covered.

16 We believe the right of the individual to
17 choose his own health method is fundamental to human
18 liberty. Chiropractic treatment, for instance, should be
19 recognized as a separate and distinct health service, not
20 provided by any other healing art and is a care sought by
21 a very large and growing proportion of Canadians annually.

22 From time to time, we hear that more econo-
23 mical hospitalization could be provided in large centres.
24 We would like to point out that birth and death do not
25 wait for weather or road conditions. Chronic patients
26 with lingering illnesses also rest easier when within the
27 reach of the love and comfort of their families. Economics
28 should not always overshadow human relations. Therefore,
29 we strongly advocate that small country hospitals be
30 retained.

31 We feel it may be necessary to provide
32 special grants to doctors to encourage them to settle in



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3 the areas serviced by these small hospitals. This would
4 tend to relieve the burden on the larger hospital centres.

5 Furthermore, we would like to see our
6 Preventative Medicines program retained and extended under
7 a National Health Plan, because this has proven very bene-
8 ficial to rural people.

9 Of one thing we are certain: To ensure the
10 success of any National Health Plan, it must be preceded
11 by a thorough educational campaign to acquaint the public
12 with the mechanics of the Plan and its estimated costs.
13 We think such an educational program should be conducted
14 by the Federal Department of Health.

15 In conclusion, we would like to point out
16 that our membership favors a comprehensive Health Plan at
17 the lowest possible cost. At the same time, our people
18 do not wish to feel that they are receiving something for
19 nothing. This is one reason they believe there should be
20 a personal premium set at a level which can be met by all
21 self-supporting persons.

22 THE CHAIRMAN: Thank you very much, Mrs.
23 Aitken. May I say your brief, although you say it is a
24 short one, is certainly expressed in language of clarity
25 and precision. The tenor of your brief is that you
26 favour a National Health Plan: could you explain just a
27 little further what you mean by a National Plan?

28 MRS. AITKEN: Well, I think we have
29 mentioned we feel it should be subsidized actually by the
30 Federal Government, but at the same time there should be
a personal premium, and we think it should cover ---

THE CHAIRMAN: Perhaps I did not make myself



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3 clear. I am thinking in terms of the word "national".
4 Do you mean by "national" one on the Federal level?

5 MRS. AITKEN: This is right; across
6 Canada.

7 THE CHAIRMAN: Just what do you have in
8 mind -- if you have carried your thinking that far --
9 that the Federal authorities should do besides furnishing
10 money?

11 MRS. AITKEN: Well, the very first thing
12 we think they should do is conduct a thorough educational
13 campaign to acquaint the people with the meaning of a
14 plan of this magnitude. Outside of subsidizing the plan,
15 further than that, we haven't gone into any great detail.

16 THE CHAIRMAN: Does the Manitoba Farmers'
17 Union accept the proposition that any health services
18 plan must be provincially operated?

19 MRS. AITKEN: We think it should be.

20 THE CHAIRMAN: Administered?

21 MRS. AITKEN: Yes, provincially administered.

22 THE CHAIRMAN: And do you see that the
23 plan should be the same in each province -- Manitoba,
24 Saskatchewan, Alberta -- or any of the other provinces?

25 MRS. AITKEN: I don't know; I haven't
26 given this too much thought. Perhaps some of the others
27 would care to answer.

28 THE CHAIRMAN: When we begin to discuss a
29 national health plan, then we would like to have your
30 views and get the thinking of people as to whether ---

31 MRS. AITKEN: I would say this, that when
32 I think of a national health plan I am envisioning



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MRS. ALLEN: This is right, exactly.

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3 something that will be more or less uniform across
4 Canada. This is my personal opinion, and I think the
5 thinking of most of the people in our organization.

6 MRS. McINTOSH: Mr. Chairman, I can perhaps
7 add this, that if we are going to have a plan on a
8 national level perhaps this is as good a place as any to
9 start. We have our provincial responsibilities, of
10 which we recognize health is one, but we have the same
11 thing in education: we have a diversification right
12 across the country in education. In planning a national
13 health plan perhaps we will have to change our legislation
14 to the point where we can have a plan which offers the
15 same opportunities to everyone regardless of whether they
16 are on the east coast or on the Prairies.

17 THE CHAIRMAN: Newfoundland, Manitoba or
18 British Columbia?

19 MRS. McINTOSH: Yes, and when we think of
20 a national health plan we are thinking of offering the
21 same to everybody regardless of station in life or the
22 place in the country where they live. We haven't gone
23 into the detail of it, but we think this is what would
24 be good for everybody.

25 THE CHAIRMAN: Just supposing for a
26 moment that it should not be possible to get the ten
27 provinces to sit down together and agree to a common plan?

28 MRS. McINTOSH: It is quite possible.

29 THE CHAIRMAN: What would your thinking
30 be? Should we necessarily wait until we get the ten
provinces into one way of thinking?

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3 hospital plan for the whole ten to come in. We started
4 with those prepared to come in at the time, and I think
5 our thinking would be that we should do the same with
6 the national health plan.

7 COMMISSIONER McCUTCHEON: You waited for
8 several provinces?

9 MRS. AITKEN: We had to have some.

10 THE CHAIRMAN: You had to have six repre-
11 senting a certain proportion of the total population of
12 Canada.

13 MRS. McINTOSH: But again, with this
14 education program we mentioned which would come in, even
15 if we started with less than the whole we could always
16 be bending our efforts towards a national plan. It is
17 not going to come overnight, but if Canada is going to
18 become a nation some day we are going to have to begin to
19 think on that basis rather than municipally or provin-
20 cially.

21 THE CHAIRMAN: There is no doubt that what
22 you say finds response in many places. Unfortunately it
23 does not find unanimous response in Canada: there are
24 province that are jealous of their provincial rights
25 position. So that, if you took the darkest picture and
26 you were at the position where you could not get provin-
27 cial unanimity, what then?

28 MRS. McINTOSH: Do the best we can with
29 what we have for a start.

30 THE CHAIRMAN: And that would be on a
purely provincial basis?

MRS. McINTOSH: It might have to be so,



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4 but you are going to have to start somewhere and we would
5 like to see it started. I think the feeling of our people
6 is they would like to see it started, and if enough of
7 the local people are involved in some of these things
8 we will move faster if the people understand what they
9 are getting into rather than introducing something from
10 the top down and these people are not sympathetic to begin
11 with, because ordinary people can do a lot of things when
12 they really want to.

13 THE CHAIRMAN: I think we appreciate the
14 fact that you accept in this brief that whatever is done
15 is necessarily going to cost people something and that
16 there is no expectation of getting something for nothing.
17 You do not mention the word "compulsory" in this brief:
18 have you got a view on that as to whether a plan, even on
19 a provincial basis, should necessarily be all-inclusive --
20 and that is compulsory -- or voluntary -- of course, with
21 certain percentage agreement: 75, 80 or 85%, or something
22 like that?

23 MRS. AITKEN: I think when we said we
24 recommended a comprehensive plan, what we were thinking
25 of was that it would be more or less compulsory and that
26 everyone would be covered under this type of plan.

27 THE CHAIRMAN: Everyone would have to pay
28 the premium?

29 MRS. AITKEN: Yes.

30 THE CHAIRMAN: You accept, do you, that
some may not be able to pay any premium?

MRS. AITKEN: That is right; according to
their ability to pay.

but you are going to have to start somewhere and in many ways, it is a matter of degree. It is they would like to see it started, and it enough of the local people are involved in some of these things we will move faster if the people understand what they are getting into rather than introducing something from the top down and these people are not sympathetic to begin with, because ordinary people can do a lot of things when they really want to.

THE CHAIRMAN: I think we appreciate the fact that you accept in this brief that whatever is done is necessarily going to cost people something and that there is no expectation of getting something for nothing. You do not mention the word "compulsory" in this brief. Have you got a view on that as to whether a plan, even on a provincial basis, should necessarily be all-inclusive -- and that is compulsory -- or voluntary -- of course, with certain percentage agreement: 75, 80 or 85%, or something like that?

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3 THE CHAIRMAN: How would you determine
4 that class? How would you decide into which class anyone
5 fell?

6 MRS. AITKEN: I suppose this would be
7 according to their income.

8 MRS. McINTOSH: We are doing it now with
9 the hospital plan, are we not -- in this province, at
10 least?

11 THE CHAIRMAN: That is, those who are in
12 receipt of social aid are having their hospitalization
13 premiums paid?

14 MRS. McINTOSH: Yes.

15 THE CHAIRMAN: And you think that is a
16 principle that can be invoked and perhaps developed?

17 MRS. McINTOSH: Personally I don't like it.
18 I have a lot of sympathy with a man who sits at the
19 municipal level of government and has to pass judgment on
20 whether or not one of his neighbours is eligible or not
21 eligible to have his premium paid, or should be forced to
22 pay it himself. I have a lot of sympathy, and I have
23 heard a lot of complaints from people in those offices.

24 THE CHAIRMAN: That is, the municipal
25 people upon whom this responsibility is placed?

26 MRS. McINTOSH: Yes, that is right. However,
27 I can't think of a better way, because they are closest
28 to the people, and I can't think of anybody else to put
29 the responsibility on.

30 THE CHAIRMAN: Has the Manitoba Farmers'
Union a view of participation in a program or in a plan
on a municipal basis; that is, where the municipality pays



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3 the premiums for all the residents of the municipality,
4 such as we heard is being done in the case of one or two
5 municipalities with the Manitoba Medical Service?

6 MRS. AITKEN: No, we have never considered
7 this. We have never given it any thought. We have no
8 particular views as an organization on that.

9 THE CHAIRMAN: Thank you very much,
10 ladies.

11 COMMISSIONER STRACHAN: There are possibly
12 three questions I would like to ask. For clarification,
13 I would like to know whether you ladies represent the
14 women's division of the Manitoba Farmers' Union or the
15 whole Union?

16 MRS. AITKEN: This is a very good question.
17 We represent the organization as a whole because we have
18 no women's division in the Manitoba Farmers' Union, but
19 the men in the Farmers' Union did not seem to feel they
20 should be as concerned about health as women, so they
21 told us it was one of our duties to speak for them and
22 present the organization's views. But we do not represent
23 the women's section. We are an organization, and there
24 are men and women in this organization.

25 THE CHAIRMAN: And you are doing it very
26 well.

27 COMMISSIONER STRACHAN: Is there a male
28 and female President?

29 MRS. AITKEN: Well, this is another unique
30 situation. We have a women's President and a President.
The President has always been a man, but he is designated
as the Manitoba Farmers' Union President, and the women



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4 have a women's President. It is not separate sections.
5 We work together in our organization at all levels.

6 COMMISSIONER STRACHAN: On page 4, the
7 last sentence of the second last paragraph, where you
8 say "we believe that sheltered workshops could be a tremen-
9 dous asset both to the mentally ill and for retarded
10 children", I had an opportunity of visiting a school for
11 retarded children and also a workshop just a week ago
12 yesterday morning, and I doubt very much if you mean
13 what you say here. Reading it without the word "both"
14 -- "we believe that sheltered workshops could be a tremen-
15 dous asset for retarded children": as I understand it,
16 children would not be in the workshop?

17 MRS. AITKEN: Well, yes, I agree. We
18 overlooked this, but a little before that we said retarded
19 children, regardless of their age. Anyone up to 21 years
20 of age is regarded as a child: isn't this right?

21 COMMISSIONER STRACHAN: Well, the division
22 I understood was that the children are kept in school up
23 to 18.

24 MRS. AITKEN: Yes.

25 COMMISSIONER STRACHAN: And then a workshop
26 is for any over that age. 21 may be the applicable age
27 in another province; I don't know.

28 MRS. AITKEN: Well, this is what we were
29 thinking, and perhaps when they got maybe to 15, 16 or
30 17 there would be certain things they might be able to do,
or whatever the age was. However, naturally, we would not
be in favour of children of 7, 8 and 9 being in the work-
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3 COMMISSIONER STRACHAN: Then, on page 6,
4 the first paragraph, you say:

5 "We think such an educational program
6 should be conducted by the Federal
7 Department of Health".

8 Do you feel the Federal Department of
9 Health could do a better job on this work than the
10 Provincial Departments of Health? Would they not need
11 the co-operation of the provincial bodies?

12 MRS. AITKEN: This might be true and they
13 might have to have co-operation there but when we were
14 speaking of a national health plan we thought naturally
15 that should be conducted by that particular group. The
16 reason we felt there should be a full educational
17 campaign conducted to acquaint the people with the mecha-
18 nics of the plan and the estimated cost is that some of
19 the difficulties we particularly ran into in our new
20 educational set-up in the Province of Manitoba, people
21 voted for this and afterwards we felt they did not
22 realize just what they were voting on. This is the
23 reason we felt there should be a full educational campaign
24 on a national level if we are going to have a national
25 plan.

26 COMMISSIONER STRACHAN: But you would
27 agree, to use a political term, that it should get down
28 to the grass roots as well?

29 MRS. AITKEN: Yes, definitely.

30 COMMISSIONER VAN WART: And I understand
from your brief that the voluntary plans have not reached
out into your districts satisfactorily and I also



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4 understand that you are advocating a plan subsidized by
5 the Federal Government and provincially administered.
6 Well now, if this plan is provincially administered, are
7 you visualizing administration such as we have with the
8 hospitals at the present time that would be administered
9 through a central bureau?

10 MRS. AITKEN: Yes, I think I can safely
11 say that is what we were thinking of and it should be
12 administered much the same way.

13 COMMISSIONER VAN WART: On the other hand,
14 if voluntary plans can be so extended to cover your
15 district would you have any objections to using a volun-
16 tary plan?

17 MRS. AITKEN: As we pointed out in our
18 brief, we feel under a voluntary plan many of the people
19 that perhaps need this coverage the most would be the
20 ones that would not have it.

21 COMMISSIONER VAN WART: If it was possible
22 to have the voluntary plan cover this, you would be
23 satisfied with it? I mean be subsidized and so on.

24 MRS. AITKEN: This is a rather difficult
25 question as far as we are concerned. Our membership has
26 always felt that they were not too much in favour of such
27 a plan. In the local areas we have found that they have
28 not been able to take advantage of the voluntary plans
29 up to the present time. Whether we would object, this
30 is something else - that is too strenuously - but I do
not think the feeling of our membership is that this is
the type of plan we would like.

COMMISSIONER McCUTCHEON: You said that

understand that you are advocating a plan subsidized by the Federal Government and provincially administered. Well now, if this plan is provincially administered, are you visualizing administration such as we have with the hospitals at the present time that would be administered through a central board?

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COMMISSIONER VAN WART: On the other hand,

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MRS. ALLEN: As we pointed out in our brief, we feel under a voluntary plan many of the people that perhaps need this coverage the most would be the ones that would not have it.

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COMMISSIONER MCGUINNESS: You said that



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3 you were representing the Manitoba Farmers' Union because
4 the men were not particularly interested in this. Is it
5 a fair inference that they may not even pay the premiums
6 if they can afford it?

7 MRS. AITKEN: Oh no, I do not think so.
8 I think perhaps I left the wrong impression. The men
9 have always left the health of the family to mothers.
10 Now, I think you will find where they are financially
11 able the men will be quite willing to pay the premiums.
12 I think that this has been borne out by the response to
13 the hospital services.

14 MRS. McINTOSH: I just wonder whether this
15 is a good idea to leave health to a voluntary plan. We
16 did not leave education to a voluntary plan, we felt
17 everybody needed a basic amount of education and so we
18 made education compulsory. I grant you there are parents
19 and parents and there are some who, if this is left to a
20 voluntary basis, perhaps would not take the proper care
21 of their children through joining a voluntary plan.
22 However, if it was compulsory they could not avoid it
23 without a great deal of difficulty and this is one of the
24 reasons that I have always felt there must be a certain
25 amount of compulsion in a plan like this. This will
26 cover everybody. We do have people who may have the
27 money but they might prefer to put it somewhere else.
28 There are people who think that medical care is a frill
29 if it does not touch them closely and they would not
30 provide for it.

31 COMMISSIONER McCUTCHEON: Are they not
32 entitled to that point of view?

you were representing the national farmers' union because the men were not particularly interested in this. Is it a fair inference that they may not even pay the premiums if they can afford it?

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However, if it was compulsory they could not avoid it without a great deal of difficulty and this is one of the reasons that I have always felt there must be a certain amount of compulsion in a plan like this. This will cover everybody. We do have people who may have the money but they might prefer to put it somewhere else. There are people who think that medical care is a thrill if it does not touch them closely and they would not provide for it.

COMMISSIONER McCORMACK: Are they not

entitled to that point of view?



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4 MRS. McINTOSH: Yes, but I wonder if we
5 are building a nation if we do not have to build a healthy
6 nation. It is just as important to have a healthy
7 nation as an educated nation and we never hesitated about
8 making people send their children to school. That is
9 the way I look at it.

10 COMMISSIONER McCUTCHEON: I won't ask you
11 if compulsory education has produced a highly educated
12 people.

13 MRS. McINTOSH: There is a question there.

14 COMMISSIONER McCUTCHEON: Yes, that is a
15 question.

16 COMMISSIONER GIRARD: Mr. Chairman, I
17 would like to direct my question to Mrs. Aitken. We
18 have been talking about a national health plan that
19 would cover everybody but I do not believe anyone
20 mentioned what services we would want to include in this
21 health plan.

22 THE CHAIRMAN: That is in the plan recom-
23 mended by the Manitoba Farmers' Union?

24 COMMISSIONER GIRARD: Yes. What are the
25 services they would recommend? It could be all-inclusive,
26 it could encompass a lot of services or some services or
27 a few services. Do you have any idea what are the speci-
28 fic health services you would like to see in a national
29 health plan?

30 MRS. AITKEN: We did mention diagnostic
and surgical treatment and so forth but we did not
mention anything specific. I will tell you something
that happened when I was out in the country this Fall; we

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it could encompass a lot of services or some services or

a few services. Do you have any idea what are the speci-

fic health services you would like to see in a national

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MRS. ATKINS: We did mention diagnostic

and surgical treatment and so forth but we did not

mention anything specific. I will tell you something

that happened when I was out in the country this Fall



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3 were discussing a national health plan and one gentleman
4 said: "Well, you know I was in Great Britain just after
5 the war and they have a plan there and they even supply
6 wigs. Now, I do not think we need things such as this.

7 THE CHAIRMAN: Oh, I don't know.

8 COMMISSIONER McCUTCHEON: I think for the
9 benefit of the Chairman we ought to have it.

10 MRS. AITKEN: We feel anything that was
11 necessary for the maintenance of good health. Now, this
12 is a very broad field.

13 THE CHAIRMAN: Does that include dentistry?

14 MRS. AITKEN: Yes, dentistry.

15 COMMISSIONER GIRARD: Nursing?

16 MRS. AITKEN: Yes, I would say nursing.

17 THE CHAIRMAN: And drugs?

18 MRS. AITKEN: Very much so. Anywhere you
19 go in the country this is one of the first things people
20 mention.

21 MRS. McINTOSH: And the care of our eyes.

22 MRS. AITKEN: Yes, and ear services.

23 THE CHAIRMAN: I suppose that is really
24 medical in the general sense?

25 MRS. McINTOSH: I think more of it should
26 be medical. I think many of us are wearing glasses who
27 perhaps would not have had to had we had proper care
28 earlier.

29 COMMISSIONER BALTZAN: May I say to you,
30 Mrs. Aitken and ladies, that I feel quite at home with
your very nice company because I am a member of the
Saskatchewan Farmers' Union and not just an honorary one,



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3 I have to pay annual dues. I hope I have paid up my
4 dues for this year. I call your attention to page 2 and
5 I will read:

6 "The lower income groups were found to
7 have more illness and more days of di abili-
8 lity than did the high income groups".
9 Would you say this is due to the lack of
10 medical care or also because of the lack of other necessi-
11 ties of life which are conducive to good health in this
12 low income bracket?

13 MRS. AITKEN: I would think it would likely
14 be a combination of the two. I know as I have gone
15 through the country and I think the other ladies here
16 will bear me out in this, we have come in contact with
17 people who will say "Now, I am not feeling well and I
18 think I should go see a doctor but you know if I do this
19 ---" of course, there is this inbred fear of people doing
20 this, but aside from that they would say "---well, who is
21 going to look after my family because I cannot afford to
22 hire someone to do it?" Then of course the cost of the
23 medical treatment and so forth. I think it is an economic
24 factor coupled with - I think it is perhaps basic, I
25 think it has a lot to do with it.

26 COMMISSIONER McCUTCHEON: Would you include
27 homemaker services then in your all-inclusive plan?

28 MRS. AITKEN: We thought of this and then
29 some people said "Well, perhaps we should start with a
30 certain amount and perhaps this could be included later".

COMMISSIONER McCUTCHEON: You are willing
to take one step at a time?

ques for this year. I call your attention to page 2 and

"The lower income groups were found to have more illness and more days of disability than did the high income groups". Would you say this is due to the lack of medical care or also because of the lack of other necessities of life which are conducive to good health in this low income bracket?

MRS. ALTKIN: I would think it would likely

be a combination of the two. I know as I have gone through the country and I think the other ladies here will bear me out in this, we have come in contact with people who will say "Now, I am not feeling well and I think I should go see a doctor but you know if I do this ---" of course, there is this feared lack of people doing this, but aside from that they would say "---well, who is going to look after my family because I cannot afford to give someone to do it?" Then of course the cost of the

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COMMISSIONER MCCUTCHEN: Would you include

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COMMISSIONER MCCUTCHEN: You are willing

to take one step at a time?



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4 MRS. AITKEN: Yes. It is the feeling of
5 our group that we should start with diagnostic and
6 surgical treatment and drugs and add this later. These
7 people feel whatever they get they will have to pay for it
8 and they want to pay for it but they want it to be within
9 their ability to pay.

10 COMMISSIONER BALTZAN: You are so very
11 knowledgeable about the life of farmers and farmers'
12 families, etc. As a generality, it could not be claimed
13 that more farmers are in poor health relative to other
14 large segments of the population? I mean this in general
15 terms because of farm conditions, etc., or would you know?

16 MRS. AITKEN: No, I would not know this,
17 to tell the truth, if you compare them with other groups
18 of the same income standard.

19 MRS. McINTOSH: Perhaps I could add this
20 much. A while ago we were told that farmers, for
21 instance, had fewer headaches, that is one disease we
22 are almost free from. Last week I spent a week at a
23 leadership school at Brandon and there we heard an agri-
24 cultural economist and he seemed very proud to have
25 transferred the load from the farmers to their heads.
26 I feel we are making progress now.

27 COMMISSIONER McCUTCHEON: That is the
28 trouble with economists and other experts.

29 MRS. AITKEN: We are not experts.

30 COMMISSIONER BALTZAN: On page 4 there is
a resolution:

"That any national health plan should be
administered by the provinces and financed



...and they want to pay for it but they want to be within people feel whatever they got they will have to pay for it

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COMMISSIONER SALTMAN: You are so very

knowledgeable about the life of farmers and farmers families, and. As a generalist, it could not be claimed

large segments of the population. I mean this is general

to tell the truth, if you compare them with other groups of the same income

much. A while ago we were told that farmers, for instance, had fewer headaches, that is one disease we are almost free from, last week I spent a week at a leadership school at Ironton and there we heard an agricultural economist and he seemed very proud to have transferred from and from the farmers to the banks,

trouble with accidents and other expenses. That is the

COMMISSIONER SALTMAN: On page 4 there is

and I think any national health plan should be

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3 largely by Federal grants coupled with
4 personal premiums ---"

5 My question is, do you believe that such
6 a national widespread plan that you outline would help
7 reduce or lower the personal premium that would be
8 required of the individual to pay as against the experience
9 as shown by current coverage plans?

10 MRS. AITKEN: I think that if it was
11 subsidized largely by Federal grants then premiums
12 should be lower than under a voluntary plan. This would
13 be my thinking.

14 COMMISSIONER BALTZAN: Everyone would have
15 to go in and thereby reduce the personal payment?

16 MRS. AITKEN: Yes.

17 COMMISSIONER BALTZAN: I think you answer
18 your questions much better than I ask them. You say here
19 on page 5:

20 "We believe the right of the individual
21 to choose his own health method is funda-
22 mental to human liberty".

23 Now, some of you may have seen a C.B.C.
24 TV presentation of the case concerning quacks; do you
25 believe then that there should be some safeguards and
26 vigilance in the interests of the people?

27 MRS. AITKEN: Definitely so.

28 COMMISSIONER BALTZAN: In other words,
29 while it is in our way of life that we must have the
30 freedoms to make our own choosing not only in this but
all other things, but in certain areas certain protective
measures are necessary?



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3 MRS. AITKEN: Yes, I would say so.

4 COMMISSIONER BALTZAN: And you would
5 include this thing that I mentioned in relation to certain
6 kinds of practice?

7 MRS. AITKEN: Yes, I think it should only
8 be registered people or qualified people, whatever termi-
9 nology you use, that should be allowed to practise medicine
10 or any type of medicine, chiropractors and so forth.

11 COMMISSIONER BALTZAN: Thank you very
12 much.

13 COMMISSIONER FIRESTONE: Mrs. Aitken,
14 Dr. Baltzan quoted to you a sentence on the first para-
15 graph of page 2:

16 "The lower income groups were found to
17 have more illness and more days of disabili-
18 ty than did the high income groups".

19 This statement, I take it, is based on the
20 results of the Canadian Sickness Survey conducted in 1951?
21 Can we ask you this specific question as it relates to
22 the problems of Manitoba: does the Farmers' Union know
23 that this is a fact as far as Manitoba is concerned that
24 you have people in the low income groups who suffer a
25 great deal more illness and disability now than do the
26 people in high income groups or are you just basing this
27 on a projection of what happened in the Survey or what
28 was proved in the Survey ten years ago?

29 MRS. AITKEN: That is right.

30 COMMISSIONER FIRESTONE: You have no first-
hand knowledge this still holds true currently in the
Province of Manitoba?

MRS. ALLEN: Yes, I would say so.

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include this thing that I mentioned in relation to certain

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COMMISSIONER BALTAN: Thank you very

much.

Dr. Baltan quoted to you a sentence in the first para-

graph of page 2:

"The lower income groups were found to

be more susceptible to disease than the high income groups."

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results of the Canadian Disease Survey conducted in 1951?

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that this is a fact as far as Manitoba is concerned that

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hand knowledge this still holds true currently in the



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4 MRS. AITKEN: No, we have no firsthand
5 knowledge, we just projected this - we projected these
6 figures and felt there would not be too much difference
7 because of the fact of the income position of the farm
8 people today as compared to what it was in 1951.

9 COMMISSIONER FIRESTONE: You conclude on
10 the basis of what is a general observation rather than
11 a survey?

12 MRS. AITKEN: That is right.

13 COMMISSIONER FIRESTONE: That many of
14 your people, and I am quoting the next paragraph of your
15 brief:

16 "...many of our people being denied the
17 opportunity of adequate medical care
18 because of the exorbitant cost of diagno-
19 stic service, medical treatment and drugs".

20 Can you give the Commission some examples
21 where people would not go or would not see a doctor
22 because they could not afford to pay for it or they
23 would not buy the drugs that were prescribed or required
24 because they did not have the money to pay for it?

25 MRS. AITKEN: No, I would not be prepared
26 to say so-and-so. That is what you want, definite names
27 of people?

28 COMMISSIONER FIRESTONE: We are not asking
29 for names, we are just interested to see whether the
30 observations you have made in your brief are based on
specific knowledge of this happening in the rural areas
of the province or is this just a conjecture or is it
based on having talked to a number of people and knowing



MRS. ATKINS: No, we have no firsthand knowledge, we just projected this - we projected these figures and felt there would not be too much difference because of the fact of the income position of the farm people today as compared to what it was in 1951.

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this is exactly what happened, not in terms of names or
number of people but based on firsthand knowledge. In
other words, it is not a generalization but is based on
your firsthand knowledge of conditions in the rural areas
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3 MRS. AITKEN: This is not a projection.
4 This is individual cases, where you go visiting a home
5 and the people will relate certain instances to you.
6 This is firsthand.

7 MRS. McINTOSH: Sir, I have been the
8 women's President of our organization for seven years.
9 Our work takes us out into all parts of the province,
10 and very often we stay in homes, rather than hotels, for
11 the convenience of our members who provide transportation
12 for us. When staying in homes, we come across some
13 rather frightening things, because women become confiden-
14 tial, and even the men become confidential with us. We
15 know for sure there are women and men too, in this
16 province who need medical care, and perhaps need surgery
17 drastically, but they have two reasons for not getting it.
18 One is the financial cost, which is direct. The other
19 is indirect, because they cannot afford to get anybody
20 else to do the work and look after their homes while
21 they go to receive the surgery. Another group is one for
22 which money is not the most important thing. They are
23 afraid to go, because they are afraid of what the doctor
24 is going to tell them they will have to do to continue
25 with the treatment. Definitely this problem exists.

26 COMMISSIONER FIRESTONE: Would you say,
27 madam, that if there were a comprehensive plan such as
28 you recommend, providing universal coverage for all
29 residents, that many of those people who are not seeing
30 a doctor because they cannot afford to do so would make
use of these expanded facilities that are becoming
available to them?

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women's President of our organization for seven years. Our work takes us out into all parts of the province, and very often we stay in homes, rather than hotels, for the convenience of our members who provide transportation for us. When staying in homes, we come across some rather frightening things, because women become confidential, and even the men become confidential with us. We know for sure there are women and men too, in this province who need radical care, and perhaps need surgery drastically, but they have two reasons for not getting it. One is the financial cost, which is direct. The other is indirect, because they cannot afford to get anybody else to do the work and look after their homes while they go to receive the surgery. Another group is one for which money is not the most important thing. They are afraid to go, because they are afraid of what the doctor is going to tell them they will have to do to continue with the treatment. Definitely this problem exists.

COMMISSIONER FLESTONE: Would you say, madam, that if there were a comprehensive plan such as you recommend, providing universal coverage for all residents, that many of those people who are not seeing a doctor because they cannot afford to do so would make use of these expanded facilities that are becoming available to them?



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4 MRS. McINTOSH: I have always felt that
5 they would, because in talking to them the majority of
6 the time it was this problem of finances that was
7 bothering them.

8 COMMISSIONER FIRESTONE: You realize that
9 a medical care plan, even as comprehensive as you suggest,
10 will not affect the attitude of a person, whether or not
11 he should see a doctor. All the scheme will provide is
12 the opportunity to see a doctor, and not being penalized
13 for not being able to pay the premium. Do you think
14 this would benefit the people in the rural areas of
15 Manitoba?

16 MRS. McINTOSH: Yes I do.

17 COMMISSIONER McCUTCHEON: Even although
18 there has been no suggestion as yet that would provide
19 somebody to run the farm while you were in the hospital?

20 MRS. McINTOSH: Well, you see sometimes
21 we have enough money that you could pay half of the cost.
22 If you didn't have to pay for the surgery, you might be
23 able to raise enough money for somebody to stay in the
24 home, but when you are faced with both, it becomes an
25 obstacle that you cannot see your way around.

26 COMMISSIONER FIRESTONE: In other words,
27 you say it will help significantly, it will not solve
28 all problems, but it will help significantly. Mrs.
29 Aitken, I come to your recommendations on page 3 at the
30 bottom, where you recommend a comprehensive medical care
program with universal coverage of all residents of
Manitoba. We asked the Manitoba Medical Association what
their objections were to a comprehensive tax-supported

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3 medical scheme, compulsory for all, and as I recall it
4 they mentioned a number of reasons, including three
5 which I would like to re-state to the best of my memory.

6 (1) Such a comprehensive compulsory program
7 would (1) reduce the extent of medical services; (2)
8 reduce the quality of medical services; and (3) reduce
9 the income of physicians.

10 Do you, as representatives of the Manitoba
11 Farmers' Union, accept these as valid reasons for not
12 implementing a comprehensive medical care program with
13 universal coverage of all residents of the Province of
14 Manitoba?

15 MRS. AITKEN: Well, I think we feel that
16 if this would provide the people in the province, or
17 give the opportunity to better health, and I feel that
18 if we feel that health is the most important thing that
19 anybody can have, we couldn't consider these valid
20 reasons.

21 COMMISSIONER FIRESTONE: In other words,
22 you do not consider them as standing in the way of a
23 national medical health plan, as you have recommended,
24 with qualifications on the word "national" as has been
25 brought out in discussion, and the questioning by our
26 Chairman?

27 MRS. AITKEN: No, I don't think this neces-
28 sarily should stand in the way.

29 COMMISSIONER FIRESTONE: May I now turn
30 to the recommendation on page 4, the sub-paragraph, in
which you speak of a national health plan administered
by the provinces, and then you continue to say financed

they mentioned a number of reasons, including three

which I would like to re-state to the best of my memory.

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Farmers' Union, accept these as valid reasons for not

implementing a comprehensive medical care program with

universal coverage of all residents of the Province of

MRS. ALLEN: Well, I think we feel that

if this would provide the people in the province, we

give the opportunity to better health, and I feel that

it we feel that health is the most important thing that

anybody can have, we couldn't consider these valid

COMMISSIONER FLETCHER: In other words,

you do not consider them as standing in the way of a

national medical health plan, as you have recommended,

with qualifications on the word "national" as has been

brought out in discussion, and the questioning by our

Chairman?

MRS. ALLEN: No, I don't think this necessary.

seemingly stand in the way.

COMMISSIONER FLETCHER: May I now turn

to the recommendation on page 4, the sub-paragraph, in

which you speak of a national health plan administered



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3 largely by Federal grants, coupled with personal premiums
4 set at a level which can be met by all self-supporting
5 persons. Do I take it that this sentence means that
6 those who cannot afford to pay these premiums, that
7 their premiums should be paid out of general revenue, or
8 putting it broadly, in the form of subsidies to such a
9 scheme?

10 MRS. AITKEN: Well, I don't know if we
11 had pursued it to this line. Our thinking was that at
12 the present time all people actually are covered with
13 hospital care. If they are not able to meet their
14 premiums themselves, then the municipality more or less
15 picks up the tab, and we were thinking that under a
16 national health plan something such as this should be
worked out for it as well.

17 COMMISSIONER FIRESTONE: I take it when
18 you say the municipality picks up the tab, you are
19 referring that this premium is paid by another source,
20 and that source is government, whether that government
21 is local government, Provincial Government or Federal
Government?

22 MRS. AITKEN: Yes, that is right. Well,
23 this would be the only other place they could find this
24 revenue.

25 COMMISSIONER FIRESTONE: We quite agree.
26 We just want your views that you are in favour of govern-
27 ment payments from some level to cover the premiums of
28 those who cannot pay them, through no fault of their own,
they have a very low income, is that correct?

29 MRS. AITKEN: Yes, that is correct.
30

largely by Federal grants, coupled with personal premiums set at a level which can be met by all self-supporting persons. Do I take it that this sentence means that those who cannot afford to pay these premiums, that their premiums should be paid out of general revenue, or putting it broadly, in the form of subsidies to such a scheme?

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4 COMMISSIONER STRACHAN: In that connection,
5 relative to this paragraph, why do you state financed
6 largely by Federal grants?

7 MRS. AITKEN: Well, because we feel that
8 a plan such as this would be quite expensive, and it
9 would be necessary for the Federal Government to pay a
10 large share of the cost, because after all they do take
11 a large share of the tax dollar.

12 COMMISSIONER FIRESTONE: Mrs. McIntosh,
13 you spoke of having some slight reservations about the
14 system of placing the burden on municipal officials to
15 decide who should and who should not be paying a premium
16 under the hospital plan, and applying this same principle
17 to a medical care program, and you further added, if I
18 understood you correctly, that you were going along with
19 the idea reluctantly in the absence perhaps of an alter-
20 native. How would the following alternative appeal to
21 you? Would you accept, for example, an arrangement that
22 people who do not pay income tax would be exempt from
23 premium payments? Presumably people who do not pay income
24 tax are in the lower income brackets, and they are for
25 reasons that the Federal Government has decided, their
26 income is low enough that they should not be taxed.
27 Would you feel that that would be a simpler system of
28 making a distinction between these?

29 MRS. MCINTOSH: That would be very simple
30 if the income tax level and exemption levels and every-
thing remained as they are today, but if the problem was
to collect income tax in future, I wouldn't say, because
we haven't any conception of what this tax would be based

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3 on. I think it is a very fair way. Income tax is
4 perhaps the fairest way of judging income that we have
5 today.

6 COMMISSIONER FIRESTONE: Under the present
7 level of income tax exemptions, would that be fair?

8 MRS. McINTOSH: Yes it would.

9 COMMISSIONER McCUTCHEON: What you are
10 really suggesting in your last sentence is that as more
11 and more of these costs are placed on government, more
12 and more people are going to pay income taxes, and you
13 are going to get into perpetual motion?

14 MRS. McINTOSH: The farmers have always
15 paid their share of taxes ---

16 COMMISSIONER McCUTCHEON: I was not sugges-
17 ting you were not.

18 MRS. McINTOSH: Well, if we had the income,
19 I am suggesting we would be prepared to pay our share of
20 the cost.

21 THE CHAIRMAN: Thank you very much Mrs.
22 Aitken and your associates, and I am sorry that we held
23 you back from this morning, but we are very grateful to
24 you for having been here.

25 We will now hear from the Society for
26 Crippled Children and Adults of Manitoba.

27 THE SECRETARY: The next submission, sir,
28 will be Exhibit 62.

29 --- EXHIBIT NO. 62: Submission of the Society for Crippled
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Children and Adults of Manitoba.



SUBMISSION OF THE SOCIETY FOR CRIPPLED
CHILDREN AND ADULTS OF MANITOBA

Appearances: Mr. A.L. Campbell
Miss Anna Speers
Mr. J.A. Carmichael

MR. CAMPBELL: Chief Justice Hall and Commissioners, this submission is on behalf of the Society for Crippled Children and Adults of Manitoba. We have filed our brief. I think to assist the Board, we will start with the conclusions on page 10, and with your indulgence I will read those, and then the recommendations which we have made.

The Society for Crippled Children and Adults of Manitoba feels there is more vitality in any program on which government and voluntary agencies have co-operated and co-ordinated their efforts. Its Board does not consider it solely a charitable organization, but rather as a community service which has a great deal to offer to the public.

The Society also feels that government agencies in the health field should see that basic needs for rehabilitation of the disabled should be met. Then, the voluntary agency can follow up by providing the other needs which complete a rehabilitation program. Such an agency can be oriented to the individual to a greater degree than can a governmental agency and, therefore, the voluntary group is a vital part of most health and welfare programs. It is the voluntary agency that continues to point up needs and to develop programs, as well as to solicit government support for such work.

At present, the Society feels that its

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3 interpretation of a crippled child limits service to
4 children with locomotor disabilities. However, until
5 more financial aid is forthcoming, the interpretation
6 cannot be extended because of lack of funds.

7 Because of the number of disabilities that
8 are not eligible for services from the Society, private
9 doctors often fail to use all of the services which the
10 Society does render. Again, medical men think of the
11 Society merely as a charitable organization and tend not
12 to refer patients who are economically well off. Both
13 of these conditions point up the need for further re-education
14 of the public at large, and the medical profession
15 in particular.

16 Again, because of the disabled people not
17 included in the Society's definition of a crippled person,
18 several small organizations may be formed for specific
19 disease entities. A multitude of organizations thus
20 confuse the community and duplicate fund-raising appeals
21 and administrative costs.

22 At present, there is a lack of adequate
23 research being done in the field of rehabilitation. In
24 the field of medical research, special interest groups
25 have started their own medical research. Much of this
26 could be taken over, on request, by the new Medical
27 Research Council. However, these groups are often
28 emotionally involved, and if the major function of
29 financing research were taken away, they might attempt to
30 enter the service field.

31 There is also a problem with continuity
32 of medical attention for staff patients in hospitals.



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4 a few months. This is a special problem when a person
5 is switched from the children's to the adults' program
6 at the age of 18. Up until then the Society may assist
7 in payment for treatment with a private doctor; from 18
8 on, a patient is turned over to the Out-Patient Department.

9 There is a very serious shortage of
10 professionally trained people now to work in the field of
11 rehabilitation. For example, there are so few psychia-
12 trists available it may take some time for a patient to
13 get an appointment. Even when he does, any program
14 suggested by the psychiatrist is difficult to implement,
15 because of the shortage of trained personnel.

16 The Society feels that better training
17 should be given to professionals so that they have
18 enough confidence to work well within their own field
19 while acknowledging the strengths which other professions
20 can also bring to a patient. If this can be achieved
21 there is the maximum benefit from a team pulling in the
22 same direction for the benefit of each and every patient.

23 There is a real need for a better long
24 term convalescent service in the Winnipeg Children's
25 Hospital.

26 It must always be remembered that children's
27 rehabilitation is different from that of adults. It is
28 geared to a changing of development levels and because
29 of this should be kept separate from any adult rehabilita-
30 tion program.

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4 mentally retarded. Patients who are disabled and also
5 severely mentally retarded are a problem which cannot be
6 easily absorbed into present rehabilitation programs.

7 Psychiatric patients who are referred to
8 the Society cannot be helped by the organization as yet.
9 This shows a great need which is not being met in or by
10 the community at large. Clients with minor disabilities
11 but with major personality problems often ask for help.
12 Although staff members are not equipped to offer the
13 needed assistance they do try as there is no other
14 community service available. These attempts often
15 detract from the program of regular service offered by
16 the Society.

17 The Society has found that academic up-
18 grading of the disabled is a problem because only March
19 of Dimes funds are available in a limited way for this
20 work. Because of this a client is often placed where he
21 is eligible to work, rather than where his needs might be
22 best met.

23 There is a need for pre-school attention
24 to the deaf child, and those with severe hearing losses.
25 Such a service for these very young children and their
26 parents could be beneficially combined with the present
27 pre-school cerebral palsy program. Plans are underway
28 for the development of such a combined service. See
29 Appendix II.

30 I will now deal with the recommendations
of the Society.

1. That the Society for Crippled Children
and Adults of Manitoba, as the central rehabilitation



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1. That the Society for Crippled Children and Adults of Manitoba, as the central rehabilitation



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3 agency in the province, be strengthened and be encouraged
4 to develop expanded rehabilitation programs. Only in
5 this co-ordinated way can the maximum benefits accrue
6 to the individual patients involved.

7 2. That there be a review of the federal-
8 provincial grants made in the children's field. At
9 present, lack of money is a limiting factor in the
10 Society's acceptance of physically handicapped children.
11 This has resulted in unfilled needs, of which the Society
12 is aware.

13 3. That a more active program of recruit-
14 ment and adequate bursaries be undertaken so that the
15 problem of a dearth of professionally trained people in
16 rehabilitation work can be solved. The government
17 should ensure that its training grants are open to any
18 student going into the field of rehabilitation.

19 4. That more research be done in the
20 broad field of rehabilitation. All aspects of a person's
21 life, his being, doing, and feeling are affected by a
22 physical handicap. Therefore, rehabilitation services
23 involve equal consideration of medicine, social work,
24 vocational and psychological factors. In the field of
25 medical research, special interest groups are carrying
26 out research which might be done more effectively on
27 request by the new Medical Research Council.

28 5. That attention be given to the problem
29 of continuity of medical advisors for staff patients,
30 particularly in the Winnipeg Children's Hospital. When
doctors rotate services fairly frequently, it may result
in lack of continuity of medical care.

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5. That attention be given to the problem of continuity of medical services for adult patients, particularly in the Winnipeg Children's Hospital where doctors rotate services fairly frequently, in any event, in lack of continuity of medical care.



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4 6. That more adequate convalescent facili-
5 ties be made available to long term patients, whether on
6 the basis of group hospital care or individual foster
homes.

7 7. That in institutions offering rehabili-
8 tation services to both children and adults, recognition
9 should be given to the different needs of children.
10 Programs should be kept separate and developed with
11 regard to the particular requirements of those being
given service.

12 8. That a program be developed for the
13 rehabilitation of psychiatric patients.

14 9. That more recreational programs for
15 the disabled be made available in the existing framework
16 of the community.

17 10. That new facilities be developed to
18 give diversionary programs to such groups as the severely
19 physically handicapped.
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4 11. That consideration be given to the
5 needs, such as transportation, board and room, etc., of
6 patients coming into Winnipeg, so that they can best
7 avail themselves of medical attention, speech therapy,
8 physiotherapy, and occupational therapy, and other rehabi-

9 12. That the Manitoba Government take
10 responsibility for the provision of funds and facilities
11 for the educational upgrading of the handicapped.

12 13. That more thought be given to public
13 buildings and their use for handicapped persons. Steps,
14 stairs, washroom facilities, etc. often make such
15 buildings inaccessible.

16 14. That the Manitoba Rehabilitation
17 Commission become a functioning group again with major
18 responsibility for public education, for the values of
19 rehabilitation, and consciousness of the need for rehabili-

20 THE CHAIRMAN: Thank you very much, Mr.
21 Campbell. In the event of a comprehensive program of
22 health services being inaugurated, that would of necessity
23 affect the function of your Society. Are you in a posi-
24 tion to say just what would be the continuing function
25 of your Society in the event of a comprehensive program
26 of health services being put into operation?

27 MR. CAMPBELL: No. I think it would be
28 extremely difficult because I think the only answer would
29 be based on what the actual program put forward would be.
30 However, we would hope if such a program were put in
force that one of the aspects would be rehabilitation in

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16. CAMPBELL: Now I think it would be extremely difficult because I think the only answer would be based on what the actual program put forward would be. I think that one of the aspects would be rehabilitation in



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3 whatever way might be thought best.

4 THE CHAIRMAN: Do you see your Society
5 passing out of the picture -- that is putting it another
6 way?

7 MR. CAMPBELL: Our prime thought is that
8 our Society is presently in partnership with the functions
9 included in the various grants and the public subscrip-
10 tions from the various appeals, and we think it is
11 rather essential to keep this voluntary service going.
12 We think it is good for society, and this is applicable
13 to all organizations, rather than having just a solely
14 government agency running it without any voluntary help
15 at all. But it might be possible, if this was not the
16 case, that we could pass out of existence.

17 Mr. Carmichael would like to say a few
18 words.

19 MR. CARMICHAEL: I think when we think in
20 terms of rehabilitation we think of more than just the
21 health aspect. The health aspect is the beginning, and
22 if we have good medical services and good treatment it
23 makes other aspects of the rehabilitation plan much more
24 effective. Supposing we did have the Utopia of a good
25 health plan, including all hospital and medical, I think
26 we have still many of the problems we have today in rehabi-
27 litation. We have many people who although these services
28 are available are unable to use them. They have fears;
29 they have suspicions about these services and they may
30 need help with them. For example, a person needing an
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3 again. He may think the world has come to an end when
4 he has lost his leg. So, I think there will still be a
5 wide scope for an agency such as ours even though a
6 health plan did come in. Rehabilitation will go on from
7 there into the field of vocational training and more
8 independence in their own self-care.

9 THE CHAIRMAN: Is this right, that the
10 principal source of your revenue, of your funds, now
11 comes from voluntary donations?

12 MRS. SPEERS: Approximately 60%, sir,
13 comes from voluntary agencies -- just under the 60%.

14 THE CHAIRMAN: Have you any view on this:
15 that if a comprehensive program of health services did
16 come into being whether that would prejudicially affect
17 the charitable giving on which you now depend for so
18 much of your activity?

19 MRS. SPEERS: I shall attempt to answer
20 that, sir. I think we have to believe that the more
21 government participation in any program, the greater the
22 tendency on the part of the general public is to say,
23 "Well, let them carry it all". But I also think that
24 within the general public there is this very important
25 latent requirement that they do feel in some measure
26 still their brother's keeper, no matter how much we have
27 a government scheme, and there must be a framework within
28 which they are able to carry out that better part of
29 their human nature which enables them to do something
30 which they believe is worthwhile to the community. I
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3 THE CHAIRMAN: Thank you very much.

4 COMMISSIONER BALTZAN: Could you perhaps
5 outline for us how you presently co-ordinate your activi-
6 ties with the Manitoba Rehabilitation Commission?

7 MR. CARMICHAEL: The Manitoba Rehabilita-
8 tion Commission serve a very good initial function.
9 When the rehabilitation program was extended prior to
10 1955, it was a body to help initial guiding, but of
11 recent years it seems to have lost the function and has
12 not been active, and we think this is a loss for the
13 pulse of the community and the voice of the community
14 to help in this co-ordinated voluntary and government
15 effort.

16 COMMISSIONER BALTZAN: Could you say what
17 accounts for the loss of interest or action?

18 MR. CARMICHAEL: I don't think I can.

19 COMMISSIONER BALTZAN: Only that it has
20 happened?

21 MR. CARMICHAEL: Yes.

22 COMMISSIONER STRACHAN: In that connection
23 is the Manitoba Rehabilitation Commission still in
24 existence?

25 MRS. SPEERS: Yes, sir; not functioning,
26 but in existence.

27 COMMISSIONER STRACHAN: Not as actively
28 as it did in former years. In paragraph 12 of your
29 recommendations you refer to the fact that the Manitoba
30 Government takes the responsibility for the provision of
funds and facilities for educational upgrading of the
handicapped; do they in any way contribute at the present

THE CHAIRMAN: Thank you very much.

COMMISSIONER BARTON: Could you perhaps outline for us how you presently co-ordinate your activities with the Manitoba Rehabilitation Commission?

MR. GARMICHAEL: The Manitoba Rehabilitation Commission serve a very good initial function. When the rehabilitation program was extended prior to 1955, it was a body to help initial guiding, but or recent years it seems to have lost the function and has not been active, and we think this is a loss for the pulse of the community and the voice of the community to help in this co-ordinated voluntary and government effort.

COMMISSIONER BARTON: Could you say what accounts for the loss of interest or action?

MR. GARMICHAEL: Yes.

COMMISSIONER BARTON: Only that it has happened?

MR. GARMICHAEL: Yes.

COMMISSIONER BARTON: In that connection is the Manitoba Rehabilitation Commission still in existence?

MRS. SPRENG: Yes, sir; not functioning.

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3 time?

4 MR. CARMICHAEL: In this particular item
5 we are referring to the adults. It is very hard to fit
6 a 20-year-old into a school system with children, and
7 many of them will not return into that system, and some
8 that attempt it don't always succeed. The only alterna-
9 tive is a correspondence course that might be done under
10 guidance, and I think some of these people might learn
11 much faster if they were taught at their own speed with
12 groups rather than a correspondence course. As far as
13 the children are concerned, there is legislation in
14 Manitoba for the setting up in school districts of
15 special classes for handicapped children, and the school
16 district at Winnipeg has such classes referred to in the
brief.

17 COMMISSIONER STRACHAN: You are speaking
18 strictly of the handicapped of the crippled group, are
19 you -- are the crippled children handicapped mentally
too?

20 MR. CARMICHAEL: No; in this brief we are
21 referring to the physically handicapped only.

22 THE CHAIRMAN: In that same context, does
23 the school district make any contribution for the
24 crippled child who is unable to attend this special class?
25 I mean, there will be a number of crippled children who
26 are sufficiently mobile to be able to go to school, in
27 spite of the fact they are crippled, and there will be
another group who cannot go to school.

28 MR. CARMICHAEL: Those who are crippled
29 and can benefit from a regular class are assisted by
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4 devious ways to get there. Sometimes the school district
5 will assist in transportation, and sometimes not. But
6 we, as a Society, try to make sure they get there. The
7 ones who are too severely handicapped to attend a normal
8 class do attend the Winnipeg school system from the
9 suburban school systems, and in some districts it is not
10 uniform. Some districts will pay the tuition or the costs
11 of this child, but sometimes it is the combination of the
12 parents and the district, and sometimes a combination of
13 the parents and the Society, or any combination to get
14 them in. A small school district will have difficulty
15 setting up a service for a classroom for severely handi-
16 capped children. It is expensive.

17 THE CHAIRMAN: Are there some who cannot
18 go to any form of school at all?

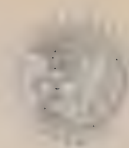
19 MR. CARMICHAEL: Yes. In parts of Manitoba
20 there is no service for these people. We have to go out
21 on individual cases and get neighbours -- housewives who
22 have been teachers and that sort of thing, and through
23 correspondence, and many different ways to try and get
24 them educated. In the City of Winnipeg there is a home
25 tutor service where these children can be taught at home,
26 but again in the suburbs this is not possible. So, it is
27 a very uneven service throughout Manitoba.

28 THE CHAIRMAN: Is there any financial
29 contribution to that by the school district?

30 MR. CARMICHAEL: In the City of Winnipeg,
yes.

THE CHAIRMAN: To that home instruction?

MR. CARMICHAEL: The school district will



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MR. CAMERON: In the City of Winnipeg,

THE CHAIRMAN: To that home instruction?
MR. CAMERON: The school district will



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3 supply the home tutor.

4 COMMISSIONER STRACHAN: You have referred
5 to the fact that approximately 60% of your funds come
6 from voluntary contributions: where does the rest of your
7 funds come from?

8 MRS. SPEERS: Principally the Federal
9 health grants. I think Mr. Carmichael knows more about
10 that and can give you the details.

11 MR. CARMICHAEL: Yes, there is a new formula
12 being worked out for 1962-63. At the present time the
13 medical rehabilitation grant is roughly shared 50-50 by
14 the province and the Federal Government. There is a
15 ceiling on this and the balance -- the Province of Manitoba
16 make an additional grant over and above this. I am not
17 sure of the figures on this, but it means that the
18 Province of Manitoba does supply a bit more than 50% of
19 the government balance.

20 COMMISSIONER STRACHAN: But you don't
21 think they are supplying sufficient funds for the senior
22 handicapped?

23 MR. CARMICHAEL: That is true, yes.

24 COMMISSIONER STRACHAN: That is what you
25 are stating in paragraph 12: in other words, funds which
26 you get from the Provincial Government are limited to a
27 certain age group?

28 MR. CARMICHAEL: I am not quite sure how
29 to answer this.

30 COMMISSIONER STRACHAN: Well, I think you
said that your recommendation in paragraph 12 referred
to the older group?

supply the home tutor.

COMMISSIONER STRACHAN: I have referred

to the fact that approximately 80% of your funds come from voluntary contributions; where does the rest of your

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said that your recommendation in paragraph 12 referred

to the older group?



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3 MR. CARMICHAEL: Oh, yes; this is the
4 educational upgrading of these people.

5 COMMISSIONER STRACHAN: You would like
6 more money from the Provincial Government for that?

7 MR. CARMICHAEL: More money or facilities
8 by them, yes.

9 THE CHAIRMAN: Thank you very much, Mr.
10 Campbell, Mrs. Speers and Mr. Carmichael for this brief
11 and for your attendance here today.

12 MR. CAMPBELL: Thank you.
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MR. CAMPBELL: Oh, yes; this is the

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COMMISSIONER STRACON: You would like

more money from the Provincial Government for that?

MR. CAMPBELL: More money on facilities

by them, yes.

THE CHAIRMAN: Thank you very much, Mr.

Campbell, Mrs. Speers and Mr. Campbell for this brief

and for your attendance here today.

MR. CAMPBELL: Thank you.



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3 SUBMISSION OF THE GENERAL PRACTITIONERS'

4 ASSOCIATION OF MANITOBA

5 Appearances: Dr. M. Ranosky
6 Dr. G. Kristjansson

7 --- EXHIBIT NO. 63: Submission of the General Practi-
8 tioners' Association of Manitoba.

9
10 DR. RANOSKY: Mr. Chairman, my name is
11 Ranosky and with me is Dr. Kristjansson; the third member
12 of our group was unable to get here on time.

13 THE CHAIRMAN: And you wish to make this
14 presentation?

15 DR. RANOSKY: That is right, sir. The
16 purpose of presenting this brief is primarily to point
17 out the presence of existing facilities in the rendering
18 of a service to the public -- that is, professional
19 facilities -- as well as suggestions as to how to improve
20 or at least maintain this excellent service which we
21 feel we have here in Manitoba. I think in this province
22 we have one of the finest systems in general practice
23 service for the public and it is because we enjoy certain
24 privileges here that this has been able to grow and
25 nurture itself, and we feel this should continue. The
26 fact that the public requires a certain service and
27 expects a patient-doctor relationship again prompts us to
28 feel that this attitude, or, certainly this relationship
29 should exist and it should be maintained at all costs in
30 any scheme that is being considered.



The General Practitioners' Association of Manitoba represents over seventy-five percent (75%) of active practising General Practitioners of this province and therefore is qualified to present the views of most General Practitioners of Manitoba.

The General Practitioner has always been the bulwark of medical service rendering an extremely useful type of service to the public and must form an integral part of any extended Health Schemes. This premise stems from the fact that the General Practitioner is qualified to render at least eighty-five percent (85%) of the medical care to his patients and with extra training this index can rise even higher.

In the development and formulation of a good sound program of medical care, the General Practitioner must therefore play a very important role in any such scheme by being able to render the majority of service on a more economic level.

With this in mind and to ensure that this satisfactory service be maintained and extended, it is strongly recommended that increased facilities and greater privileges be made available to competent practitioners.

Provision for increased training and improved skills are constantly being fostered by the General Practitioner through his own teaching programs in order that he will be able to render an even higher level of medical service to his patient. As General Practice was the true mainstay of every well-qualified specialist, there can be no denial by any member of our profession that General Practice is itself, in a sense a

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3 specialty, and therefore should form a part of every
4 teaching curriculum to ensure that it keep abreast of
5 medical teaching and training, in order to render the
6 highest type of service. Any increase of quality of a
7 General Practitioner service must of necessity result in
8 improved specialist service, the same being true conversely.

9 PRIVILEGES

10 No health scheme can be instituted without
11 the General Practitioner playing an important role.

12 He must be made aware of his responsibility
13 and integrated into the scheme with increased privileges
14 or he will perish through the denial of intellectual
15 nourishment and freedom of expression as races of men
16 have done in the past. There must be a resurgence of
17 thought and effort by the profession to maintain the
18 General Practitioner in his respected role in the care
19 of the sick.

20 To ensure the future of general practice
21 the medical schools must acknowledge its rightful
22 prestige and integrate general practice into its teaching
23 program which will encourage the supply of future doctors
24 in our province. Strong consideration must be given to
25 establishment of Departments of General Practitioners
26 in Hospitals where none already exist and the establish-
27 ment of chairs of General Practitioners in our medical
28 schools.

29 COST

30 It is a well known fact that when greater
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3 must include the prominent role that the General Practi-
4 tioner will play in such a scheme in order to keep it
5 workable. The effectiveness of such a role can best be
6 studied in our own prepaid medical plan which is in opera-
7 tion in this province and renders a comprehensive care
8 plan for its subscribers.

9 This association endorses the continuation
10 of such a prepaid plan with extension of services to
11 include the whole population, thereby allowing the sub-
12 scriber, control in the prepayment of his medical care.

13 THE CHAIRMAN: Thank you very much. Have
14 you anything to add at the moment, Dr. Kristjansson?

15 DR. KRISTJANSSON: No.

16 THE CHAIRMAN: Now, gentlemen, we have
17 heard quite a lot in the last couple of days about the
18 lack of doctors in the rural areas of Manitoba and the
19 figures given us indicate that the ratio of general
20 practitioners outside the metropolitan area of Winnipeg and
21 perhaps Brandon, of all the doctors in the province, out-
22 side of those areas; the general practitioners greatly
23 predominate. Now, may we start with this proposition
24 that this matter of servicing the rural areas is essen-
25 tially the function of the general practitioner?

26 DR. KRISTJANSSON: I disagree there, I
27 think that is not the primary function. The major portion
28 of our population is centred in Winnipeg, therefore, a
29 general practitioner's function is just as important in
30 the city.

THE CHAIRMAN: I accept that quite readily
but I am just talking now and directing my question to the



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DR. KRISTJANSSON: I observe there, I think that is not the primary function. The major function of our population is centered in Winnipeg, therefore, a general practitioner's function is just as important in the city.

THE CHAIRMAN: I accept that quite readily.



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3 rural areas and to those who, in the nature of things,
4 will practise in the rural areas. Now, has the group,
5 that is the general practitioners group, given considera-
6 tion to the developing of group practices in rural areas?

7 DR. RANOSKY: Well, there are at present
8 certain rural areas that do have small groups of two or
9 three men associated in practice in order to improve
10 services they are able to give.

11 THE CHAIRMAN: Those are partnerships,
12 as you would call them?

13 DR. RANOSKY: They usually have their own
14 arrangements of one kind or another whether they are
15 partnerships or just associates - it varies.

16 THE CHAIRMAN: They are in the same
17 building?

18 DR. RANOSKY: Yes.

19 THE CHAIRMAN: But have you given any
20 consideration to taking the area of the province with
21 some reasonably sized town as a focal point or a central
22 point in operating as a group out of that point and
23 covering, say, an area 50 miles square or something like
24 that?

25 DR. KRISTJANSSON: That is pretty well
26 done in practice right now actually.

27 THE CHAIRMAN: Are you familiar with the
28 situation in Hamiota?

29 DR. RANOSKY: Not extremely so.

30 DR. KRISTJANSSON: It is not a large ---

THE CHAIRMAN: Is there not a group working
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3 DR. KRISTJANSSON: I think there is a group
4 of three.

5 THE CHAIRMAN: In which they operate out
6 to various surrounding towns and communities?

7 DR. KRISTJANSSON: Yes, that is right.

8 DR. RANOSKY: What they have really done
9 is take their territories and pool them. They are
10 still rendering the service to the same areas that they
11 serviced before.

12 THE CHAIRMAN: Yes, but they do not all
13 live in Hamiota?

14 DR. RANOSKY: No, not necessarily.

15 THE CHAIRMAN: Has the general practi-
16 tioners' group really made any study of the possibility
17 of group practice as the way to service rural communities?
18 I mean, to service it and service it effectively and to
19 perhaps give equivalent service to that given in the
20 metropolitan area?

21 DR. RANOSKY: There has been no organized
22 study of this problem made to date.

23 THE CHAIRMAN: Now, you say you endorse
24 the contention of the prepaid plan with the extension of
25 services to include the whole population. How do you
26 propose in that recommendation to get the whole population?

27 DR. RANOSKY: I think the topic is very
28 well covered in the other brief.

29 THE CHAIRMAN: You adopt the same general
30 principle of a subsidy on those who are unable to pay the
full premium?

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3 THE CHAIRMAN: You see, twice in this
4 memorandum you use the expression "greater privileges
5 be made available"; what do you mean by that?

6 DR. RANOSKY: Well, this stems primarily
7 from the fact that there is up until a short time ago,
8 I believe, and perhaps in certain areas it still exists,
9 there has been a tendency to stem the general practitioner
10 in his practice.

11 THE CHAIRMAN: Is that intra-professional?

12 DR. RANOSKY: By that I mean there is a
13 tendency to remove him out of the hospital in rendering
14 a service.

15 DR. KRISTJANSSON: Super-specialization.

16 THE CHAIRMAN: But this is a growth within
17 the profession itself, or is it produced by government or
18 hospital management?

19 DR. KRISTJANSSON: That is right.

20 THE CHAIRMAN: Which?

21 DR. KRISTJANSSON: Hospital management,
22 sometimes it is hospital management, sometimes it is
23 intra-professional but the general trend at times seems
24 to be a restriction of general practitioner privileges.

25 THE CHAIRMAN: Whatever causes it the
26 general practitioner is out in the cold?

27 DR. KRISTJANSSON: Yes, and we think it is
28 bad for the public because he is giving the cheapest care.

29 COMMISSIONER BALTZAN: Can you categori-
30 cally say that a general practitioner is excluded or
deprived of the privilege of treating his patient in the
hospitals, that he is kept out of the hospitals? Can you

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3 make that statement?

4 DR. RANOSKY: No. As I mentioned earlier,
5 in this province we enjoy more privileges than most
6 other provinces. We certainly endorse the principle of
7 continuing this kind of practice because we feel it is
8 the best service any general practitioner can give
9 because he must then be on his toes in order to keep up
10 and render a service that is high in quality. We enjoy
11 certain hospital privileges here, yes.

12 DR. KRISTJANSSON: We do not feel we are
13 restricted here.

14 COMMISSIONER McCUTCHEON: That is not
15 enjoyed by general practitioners in other provinces?

16 DR. KRISTJANSSON: That is right.

17 COMMISSIONER BALTZAN: And you say it is
18 a beginning trend or a trend that is already in vogue or
19 rather the opposite, particularly referring to the west
20 where G.P.'s run their own hospital in small areas and
21 in larger cities where they are on the staffs of most
22 hospitals. That is quite a big difference, that is quite
23 a big difference in relation to the older and larger
24 metropolitan areas. Certainly in the west it is different.
25 I believe that perhaps you have in mind that once you are
26 in the hospital which is departmentalized and you cannot
27 serve in all departments. By that you mean, therefore,
28 that your privileges are curtailed. Would you say then
29 it is in the best interests of good medicine or not?

30 DR. KRISTJANSSON: We think an answer to
it is to establish departments of general practitioners
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3 COMMISSIONER BALTZAN: I beg your pardon?

4 DR. KRISTJANSSON: We feel an answer is to
5 establish departments of general practitioners in our
6 hospitals.

7 COMMISSIONER BALTZAN: I think you mention
8 that a little later. On the bottom of the first page,
9 I am not too clear when you say:

10 "...there can be no denial by any member
11 of our profession that general practice is
12 itself, in a sense, a specialty, and
13 therefore should perform a part of every
14 teaching curriculum to ensure that it keep
15 abreast of medical teaching and training,
16 in order to render the highest type of
service".

17 Do you mean that any subject matter
18 pertaining to general practitioners should be part of the
19 curriculum or are you thinking in terms of general prac-
20 titioners forming a part of the teaching group in
21 training students in medicine? Which of these two do you
22 mean? More emphasis on how to be a general practitioner
23 or do you want a role, a definite role for the general
24 practitioner to be a teacher? Which one of these things
or both?

25 DR. RANOSKY: Partly both. To start with
26 I think there is a trend in medical teaching to get
27 away from developing general practitioners. Today in
28 medical schools we are more interested in being placed
29 on specialization. I think the first start has been made
to go back to what we used to have in this province, more



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4 again with emphasis on developing still better practi-
5 tioners I think a chair in the college with a general
6 practitioner taking part in the teaching program. For
7 the student going into general practice it would certainly
8 be of great value.

9 COMMISSIONER BALTZAN: Are you aware that
10 at the present time there is a trend in the direction, in
11 both directions, that more emphasis is placed on preparing
12 medical students to become general practitioners and
13 enjoy the life of a general practitioner and that general
14 practitioners are on teaching faculties of medical
15 schools. I refer particularly to the newly established
16 schools in recent times.

17 DR. RANOSKY: Yes. Well, that is the
18 point we want to make that it is a desirable sort of
19 situation that we are endorsing.

20 COMMISSIONER BALTZAN: But it is happening
21 in Canada?

22 DR. RANOSKY: Yes.

23 COMMISSIONER BALTZAN: Now, gentlemen,
24 there must be, you say at the top of page 2, a resurgence
25 of thought and effort by the profession to maintain the
26 general practitioner in his respected role in the care
27 of the sick. As a result of your department of your
28 College of general practice, has not the status of the
29 general practitioner increased or has it around the
30 college of general practice?

DR. RANOSKY: Within our own college,
yes. Whether this is nationally acceptable remains to be

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5 of the profession, especially hospital management and
6 care and staff work, that this is the case, in every
7 area that is.

8 COMMISSIONER BALTZAN: No. 2 in the same
9 matter; in the operation of the College of General
10 Practitioners which you helped to initiate and which had
11 the blessing of the Canadian Medical Association and it
12 has a section in the operation of the Canadian Medical
13 Association at general meetings, No. 2, has not the
14 refresher course contributed greatly to your ability to
15 keep abreast with advances in medical practice?

16 DR. RANOSKY: Yes, sir.
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COMMISSIONER BALTZAN: Therefore, may I ask this: since you are the majority, and you are in the whole body of medicine I think, can you not better accomplish your aims and your ambitions than other sections of organized medicine? You, as a majority with a College of General Practice, with high ambitions, can you not generate these things which will make you accomplish what you aim for? You yourselves, or would you have somebody else do it?

DR. RANOSKY: No, I think we certainly can.

COMMISSIONER BALTZAN: Lastly, gentlemen, strong consideration, and I quote, must be given to the establishment of departments of general practitioners in hospitals where none already exist, and the establishment of chairs of general practitioners in medical schools. You do recognize that there are departments of general practice in hospitals today in Canada?

DR. RANOSKY: Yes, right in the city.

COMMISSIONER BALTZAN: And that the trend is in that direction?

DR. RANOSKY: That is right.

COMMISSIONER BALTZAN: So that the only proposition remains that you would like to see a chair of general practice comparable to the chair of general surgery, or medicine?

DR. RANOSKY: Yes.

COMMISSIONER BALTZAN: And you think that that would serve a particular function, or is that function served fairly well if more and more men in general practice serve as instructors and teachers and



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4 lecturers in medical schools, would you still insist
5 that your proposition here would improve or be better
6 than accelerating this process now, this proceeding
7 where more and more general practitioners serve as
8 teachers, and instructors, and lecturers?

9 DR. RANOSKY: Yes, I think it would be
10 better, yes.

11 COMMISSIONER BALTZAN: Could we perhaps
12 at a later time have this elaborated, and give us your
13 very positive views in this direction?

14 DR. RANOSKY: Yes.

15 THE CHAIRMAN: I think perhaps the proper
16 channel would be through your medical education project,
17 Dr. Macfarland's, which is charged directly with the
18 subject of medical education, and this transcript will
19 naturally go to Dr. Macfarland.

20 COMMISSIONER VAN WART: Mr. Chairman, might
21 I ask for the record what are your qualifications to
22 retain your membership in the College of General Practi-
23 tioners?

24 DR. RANOSKY: Well, this brief is not
25 dealing with qualifications of general practice. It is
26 the Association of General Practitioners in this province,
27 but the qualifications are for membership, of five years
28 standing, associate membership two years standing, in
29 general practice, with a medical degree, and at least
30 one year's interneship.

DR. KRISTJANSSON: And then, to maintain
this requires certain minimum hours of study, at lectures,
and attending refresher courses.

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3 COMMISSIONER VAN WART: Would you elaborate
4 a little on that for the record?

5 DR. KRISTJANSSON: I think it is 96 hours
6 of organized study per year.

7 DR. RANOSKY: You have to attend besides
8 that at conventions.

9 THE CHAIRMAN: Have you got a written
10 constitution?

11 DR. RANOSKY: Yes.

12 THE CHAIRMAN: Does it contain these
13 conditions?

14 DR. RANOSKY: Yes.

15 THE CHAIRMAN: Would you file it with us
16 please?

17 DR. RANOSKY: Certainly. This will all be
18 covered in the brief of the College of General Practi-
19 tioners, which will be issued on a national scale.

20 THE CHAIRMAN: So that we will get it all
21 at that time?

22 DR. RANOSKY: Oh, yes.

23 COMMISSIONER STRACHAN: Mr. Chairman, I
24 have always been under the apparent misconception that
25 the graduate of a medical school was prepared for general
26 practice. When did this trend change, and how far has
27 it gone at the present time? Apparently the instructions
28 are coming, as I understand it, entirely from specialists,
29 and added to that, are there any colleges of medicine
30 where they have established a chair for the general
practitioners, or is it a recognized project for the
future?



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3 DR. RANOSKY: There are none that I am
4 aware of at the moment.

5 COMMISSIONER STRACHAN: When did this
6 change take place, that medical schools are not turning
7 out men qualified as general practitioners? Would you
8 say that they are not doing so at the present time?

9 DR. RANOSKY: By virtue of the fact that
10 more and more graduate students are turning to specialties,
11 because they feel that they are not qualified to turn to
12 general practice with the amount of training they receive.

13 COMMISSIONER STRACHAN: Have you any idea
14 when that took place?

15 DR. KRISTJANSSON: It is a gradual process
16 over the last years, and I think it has been partly
17 propagated by the medical schools, because you are taught
18 always by a specialist. There is no chair of general
19 practice for you to look up to. All you listen to during
20 your lectures is a specialist in internal medicine,
21 surgery, or obstetrics, or so on, and this is what they
22 look up to and their thinking trend is in that direction,
23 and when they graduate they perhaps don't feel that
24 general practice has much to offer in the way of return,
25 and that is, I think, part of the reason that there has
26 been more emphasis on super-specialization, so that all
27 graduating -- I don't know what the exact figures are,
28 but more and more they are going into the specialties.

29 COMMISSIONER STRACHAN: Well, at this
30 stage, as Dr. Baltzan has suggested and as you have
admitted in your own submission, that you represent over
75% of the active practising general practitioners, but

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stage, as Dr. Altman has suggested and as you have

admitted in your own submission, that you represent over

75% of the active practicing general practitioners, but



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3 still general practitioners are the great majority of the
4 medical profession?

5 DR. KRISTJANSSON: They are the majority
6 of the medical profession, yes, but in terms of total
7 care, in other words, if you were to take the population
8 of the Province of Manitoba and the number of specialists
9 required, if they were to restrict their practices
10 completely to their own specialties, they are more than
11 are needed, and there are not enough general practitioners
12 to do their job, if they were to do their job right, so
13 the overall picture is that there are more specialists
than are needed, and we would like to reverse this.

14 COMMISSIONER STRACHAN: Has your Association
15 made any effort to try to influence the schools to this
16 effect, or what can we do?

17 DR. KRISTJANSSON: That is the job, to
18 establish departments of general practice in the hospital
19 through your administrators, which is largely through
20 government grants that the hospitals are run now, and to
21 promote or encourage them to establish chairs in colleges
22 of general practice, and this would put more emphasis on
23 general practice, and would accomplish, I think, this
24 reversal, or partially help to reverse this trend of
specialization, which we think is one of the problems in
the country as a whole, not only in Manitoba.

25 COMMISSIONER STRACHAN: Thank you, that
26 is very enlightening to me personally, because I thought
27 medical schools graduated men who had the ability to go
28 into general practice.

29 COMMISSIONER BALTZAN: You speak of your
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3 teachers who are largely specialists. I ask you, does
4 a specialist deliver a baby different to a man in
5 general practice?

6 THE CHAIRMAN: He gets more money for it.

7 COMMISSIONER BALTZAN: I want the methods
8 for both. In other words, are these teaching specialists
9 competent to train men to do the right thing by a patient,
10 whether he later becomes a specialist, to handle more
11 delicate and complicated cases, but he is also trained
12 certainly and primarily to do good medicine in general
13 practice.

14 DR. KRISTJANSSON: But he is restricting
15 his practice, isn't he, to a certain limited field, and
16 if you consider that 80 or 85% of all medicine can be
17 done competently and completely by general practitioners,
18 I don't know what the exact figures are for the ratio
19 between specialists and general practitioners in this
20 province, but I know it is near 90 and 10%.

21 COMMISSIONER BALTZAN: You would then say
22 that this is a great compliment to the medical schools
23 in Canada?

24 DR. KRISTJANSSON: That they are producing
25 specialists.

26 THE CHAIRMAN: And with that tribute to
27 the specialists, I will thank the gentlemen who attended
28 here this afternoon, and as I said, a record of this
29 will go to the medical education project.

30 We will now have a short recess.

--- Short Recess.

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We will now have a short recess.



THE CHAIRMAN: We will now proceed with the Canadian Society of Radiological Technicians.

THE SECRETARY: This submission will be Exhibit No. 64.

--- EXHIBIT NO. 64: Submission of the Canadian Society of Radiological Technicians.

SUBMISSION OF THE CANADIAN SOCIETY OF
RADIOLOGICAL TECHNICIANS

Appearances: Mr. W. Doern
Mr. D. Butler
Mr. G.E. Carson

MR. DOERN: Mr. Chairman, with me are members of our Division, Mr. Butler, who is a member of our Advisory Committee, Mr. Carson, next to him, who is our Secretary, and my name is Doern, of the Advisory Committee.

The Manitoba Division of the Canadian Society of Radiological Technicians welcomes this opportunity to present its submission. A revision to our recommendations was necessary, and the Commission has been supplied with 25 copies of revised pages 13 to 16.

This Brief follows the terms of reference of the Survey Board although comments have not been made in all Sections (with an admission of unfamiliarity on the part of this Society with some topics), so we therefore make no comment on Sections 1, 2 and 3 and I will move down to Section 4.

SECTION 4

In Manitoba at the present time there is

THE CHAIRMAN: We will now proceed with

THE SECRETARY: This submission will be

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COMMISSION OF THE CANADIAN SOCIETY OF

Appearance: Mr. W. Hoern

MR. DEER: Mr. Chairman, with me are

members of our Division, Mr. Butler, who is a member of
our Advisory Committee, Mr. Carson, next to him, who is
our Secretary, and my name is Board, of the Advisory
Committee.

The Manitoba Division of the Canadian
Society of Radiological Technicians welcomed this oppor-
tunity to present the submission. A revision to our
recommendations was necessary, and the Commission has
been supplied with 15 copies of revised pages 13 to 18.
This brief follows the terms of reference

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A Manitoba at the present time there is



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3 a shortage in the number of qualified Technicians
4 available. Although metropolitan Winnipeg does not lack
5 personnel, rural areas are constantly harassed by the
6 movement of the personnel they have, and by the diffi-
7 culty in obtaining people willing to go to the country.

8 We feel that the causes of this phenomenon
9 are basically simple although the cures may not be so
10 simple.

11 Technicians today can probably be broadly
12 classified into four employment groups;

13 (a) Women - short term employment

14 (b) Women - long term employment

15 (c) Men - short term employment

16 (d) Men - long term employment

17 (a) Women in the short term employment
18 group are those who train with the intention of gaining a
19 useful and productive livelihood before entering into
20 matrimony and who do not expect initially to ever make a
21 life career of the vocation. Such persons make up the
22 largest percentage of graduates from our training schools
today. Women in this category of graduates are unwilling
to migrate to the rural areas because;

23 (I) They are originally from the city and
24 have a misconception of present-day rural
25 life and/or have made a social contact
26 which is about to blossom into a home of
their own.

27 (II) The rural students almost invariably
28 acquire a distinct preference for city
29 living while in the urban schools, and do
30



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4 not wish to return to the country.

5 (b & d) The reasons for the men and
6 women in the long term employment groups not wishing to
7 leave urban areas for the rural are more serious and must
8 be considered more closely. We feel these are people who
9 provide the more desirable service to the public, and who
10 must be encouraged to accept employment in country posts
11 if the rural standards of Technical facilities are to be
12 more equated with those of the city. The reasons which
13 deter both the men and women classified under long term
14 employment are somewhat similar and are presented as for
15 one group;

16 (I) a move to the country precludes a
17 limitation to advancement in technical
18 skills. Country positions generally do
19 not offer to the technician with a desire
20 for professional growth the opportunity
21 to do so because of the lack of specialized
22 forms of radiography in most rural depart-
23 ments.

24 (II) in spite of experience opportunities
25 for advancement into new job locations are
26 often restricted through lack of experience
27 with specialty techniques and equipment.
28 A technician contemplating a move to a
29 rural area might well fear that he or she
30 will get out of touch with progress, and
should better employment offer itself will
be unable to compete with persons who have
been in constant association with special



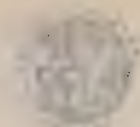
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4 procedures to date.

5 This Society feels that the opposition to
6 taking rural posts might be overcome to a very great
7 extent through the concerted action of a number of devices;

8 (I) Better public relations at high school
9 level with a special effort to remove the
10 myth that Radiography is primarily a
11 woman's field. The emphasis on the oppor-
12 tunity for both women and men to serve the
13 community in doing this important work.

14 Mention of the fact that with honest effort
15 and high technical achievement a Radio-
16 grapher should be able to enjoy above
17 average living. Such a program has already
18 been acted upon to some extent by this
19 Society by sending representatives to speak
20 at high school career days and through use
21 of brochures. However, with greater funds
22 and/or assistance from affected organiza-
23 tions such as Associated Hospitals of Mani-
24 toba this program could well be expanded.

25 (II) Refresher courses provided for techni-
26 cians at convenient locations can alleviate
27 the fear of technical personnel of becoming
28 obsolescent. Such refresher courses have
29 been provided by the National Society at
30 the site of the annual Convention for 17
years, and enrollment each year becomes
more satisfactory; however, these courses
are only available to the small percentage



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are only available to the small percentage



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3
4 who are able to travel to the site of the
5 Convention. In the past four years,
6 through the co-operation of the Canadian
7 Association of Radiologists, Manitoba
8 Division, and Associated Hospitals of
9 Manitoba, refresher courses have been
10 offered annually by the Manitoba Society,
11 and plans to expand their scope are being
12 considered. However, such courses in
13 themselves are of little value unless
14 technicians are given the opportunity to
15 attend and, if necessary, assisted in
16 doing so, particularly those persons
17 employed in the more distant rural areas.
18 In the matter of attendance we would soli-
19 cit the further aid of the Associated
20 Hospitals of Manitoba.

21 (III) Recognition of personnel services
22 provided in the form of remuneration based
23 on merit of ability or length of employment
24 should be considered.

25 (IV) The use of rotational supervisory
26 service such as is presently enjoyed in a
27 limited area in Manitoba might be extended
28 to all the rural hospitals of Manitoba.
29 Such a service tends to keep rural techni-
30 cians in contact with the profession and
would help keep interest in the field and
technique at a higher level. We feel this
supervisory service is a necessity for all



who are able to travel to the site of the
through the co-operation of the Canadian
Association of Pathologists, Manitoba
Division, and Associated Hospitals of

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attend and, if necessary, assisted in
doing so, particularly those persons
employed in the more distant rural areas.
In the matter of attendance at winter schools
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on merit of ability and length of employment
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would help keep interest in the field and
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supervisory service in a necessary form all



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3 rural technicians in Manitoba.

4 Men in the short term employment group are
5 those graduates who, after close contact with the medical
6 profession realize that they desire a higher education,
7 or else a more remunerative field.

8 SECTION 5

9 The educating of radiological technicians
10 is effected in Manitoba in a number of schools operated
11 by hospitals, and in a school administered by the Depart-
12 ment of Health of the Province of Manitoba. These schools
13 are accredited by the Joint Council on Technical Training
14 of the Canadian Medical Association, Canadian Association
15 of Radiologists, and Canadian Society of Radiological
16 Technicians. Their students are acceptable by the Canadian
17 Society of Radiological Technicians as candidates for
18 certification.

19 Schools are limited by the Council as to the
20 number of students which are to be trained at any one time.
21 This number is dependent on the number of Registered Tech-
22 nicians employed by the institution. The ratio is two
23 students for each Registered Technician employed, as indi-
24 cated in the Minimal Requirements for Approved Schools
25 for Radiological Technicians, Joint Council on Technical
26 Training, under "Faculty for Training Schools" on Page 9,
27 Sec. c.

28 On the basis of these limitations the
29 training facilities in Manitoba are at present being
30 fully utilized.

31 In the Province of Manitoba during the
32 period of 1957-1960, 75 females were trained. Of these



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3 52% have left the field. During the same period 16 males
4 were trained and of these 25% have left the field. This,
5 in figures, means that over a three-year period 39 females
6 and 4 males have been lost to Manitoba.

7 We feel that in order to keep more techni-
8 cians in the field it will be necessary to train a larger
9 percentage of males.

10 The intention is not to exclude women from
11 better jobs; but, whereas it can be shown male students
12 stay on longer after graduation, it only seems reasonable
13 to attempt to attract more males. It is the feeling of
14 the Society, however, that where women show themselves
15 to have attained a high level of experience, they prove
16 equally capable to men, and every effort should be made
to attract such women to make a career in Radiography.

17 In order to make this field more attractive
18 the Society is attempting to nurture the spirit of greater
19 service in the form of refresher courses and additional
20 training after graduation. We think this, along with
21 proper recognition for proven ability, will help achieve
this end.

22 With reference to the adequacy of educa-
23 tional facilities and method of education, we would like
24 to point out that the training schools of this Province
25 enjoy a reputation for good training programmes. We are,
26 however, in favor of some form of centralized training
scheme for the theoretical portion of training.

27 We would also like to recommend that
28 should such a training program be set up our organization,
29 along with the Canadian Association of Radiologists
30

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We would also like to recommend that should such a training program be set up our organization, along with the Canadian Association of Radiologists



(Manitoba Division), be consulted for suggestions to the program.

SECTION 6

The Canadian Society of Radiological Technicians, Manitoba Division, would consider it a privilege to submit comments and suggestions to the Survey Board in any other aspects within our field and relating to Hospital Services in Manitoba, which may be referred to the Survey Board by the Minister. We can assure you of our wholehearted co-operation.

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assure you of our wholehearted co-operation.



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3 THE CHAIRMAN: Thank you very much, Mr.
4 Doern. In your consideration of the situation in
5 Manitoba have you given thought to the idea of a rural
6 radiography centre?

7 MR. DOERN: With regard to teaching?

8 THE CHAIRMAN: No; with regard to practice.

9 MR. DOERN: Well, of course, you understand
10 that technicians practise in a hospital and only under
11 the supervision of a medical practitioner.

12 THE CHAIRMAN: But have any of the hospi-
13 tals developed a concentrated program in any of the
14 larger rural centres?

15 MR. DOERN: Yes, this is where the Provin-
16 cial Department of Health comes in; they are very effec-
17 tively doing that sort of work.

18 COMMISSIONER GIRARD: In the centralized
19 program that you are contemplating here, would this mean
20 that the theory would be given in one school but then
21 that the students could go out to different hospitals to
22 do what we call field work or practice work?

23 MR. DOERN: We would hope if the central
24 scheme were set up that the hospitals which are at present
25 training technicians would remain in that capacity, and
26 the students would be their students and be sent to this
27 centre for theory only.

28 COMMISSIONER GIRARD: Could the students
29 be sent to the rural hospitals and therefore perhaps
30 enjoy rural life and want to stay there later on, or is
there difficulty in sending them to rural hospitals for
their practice because they would not have sufficient



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3 supervision in the rural hospitals?

4 MR. DOERN: This is something that can be
5 tried, but if it could be done it would be the answer.

6 COMMISSIONER GIRARD: This has been tried
7 in nursing for the same reason. Sometimes if the person
8 goes out to the rural field for one reason or another,
9 she likes it and she may be enticed to stay in the rural
10 field.

11 MR. DOERN: The suggestion has been made,
12 but it has not been very well accepted.

13 COMMISSIONER GIRARD: This could be a
14 practical side of the centralized program, although the
15 centralized program has a lot of merits. It has been
16 tried in other fields and has been recognized as having
17 merits, and in your special difficulty of getting people
18 for rural areas this could be one of the advantages.

19 MR. DOERN: We think we have a suggestion
20 for partly overcoming this rural problem in that a man
21 can make his life in the rural area and be very comfortable
22 and spend years there and make it his life's work. A male
23 technician, we think, would settle down in the rural area
24 provided it was made attractive enough, and we think they
25 could live quite comfortably and be very happy, and we
26 would like to see it tried.

27 COMMISSIONER GIRARD: Would the salaries
28 be the same in the rural areas as in the urban areas for
29 the same kind of employment -- the same services?

30 MR. DOERN: Yes. At the present time, I
think I am right in saying they are probably better.

COMMISSIONER GIRARD: And the lower cost

MR. DOLAN: This is something that can be

tried, but if it could be done it would be the answer.

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3 of living, and the same or higher salary...?

4 MR. DOERN: A higher salary and lower cost
5 of living is quite attractive. There are some who think
6 this being a woman's work, they don't want to go into
7 this, but with a proper public relations job, we would
8 like to see this tried.

9 COMMISSIONER GIRARD: Proper exposure of
10 rural life too?

11 MR. DOERN: Yes.

12 COMMISSIONER VAN WART: Do many students
13 come from country districts?

14 MR. DOERN: Yes, in our institution we
15 get quite a number -- a fairly high percentage -- and I
16 don't know of one who has ever gone back.

17 COMMISSIONER VAN WART: Federal health
18 grants: are they available for training of x-ray techni-
19 cians?

20 MR. DOERN: That is something I am not
21 familiar with, but I would like to suggest there are
22 students who cannot afford to take it, and I think they
23 may be assisted by some financial organization.

24 COMMISSIONER STRACHAN: Is there any salary
25 to begin with?

26 MR. DOERN: In most institutions in Manitoba,
27 to the best of my knowledge, there is some remuneration
28 in the form of living allowance. That is about as far as
29 it goes.

30 COMMISSIONER STRACHAN: Are there many who
start training and give it up without completing it?

MR. DOERN: We have a very low percentage;

of living, and the same or higher salary...

MR. DUBIN: A higher salary and lower cost

of living is quite attractive. There are some who think

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3 I would say less than 2% -- I should probably say we have
4 had of late more than 3% -- not because they don't like
5 it, if that is what you mean.

6 COMMISSIONER STRACHAN: Or, the desire to
7 go on.

8 COMMISSIONER BALTZAN: I have just one
9 question but, first, gentlemen, I compliment you... You
10 have explained your position extremely well, and also
11 you offer the necessary remedies very clearly. On the
12 second page, paragraph 10, item (II), the last portion:

13 "A technician contemplating a move to a
14 rural area might well fear that he or she
15 will get out of touch with progress, and
16 should better employment offer itself will
17 be unable to compete with persons who have
18 been in constant association with special
19 procedures..."

20 and then, at the bottom of the page, in item (II) you do
21 say there are refresher courses and such courses have
22 been provided by the National Society at the site of the
23 annual convention. It is clearly stated that there are
24 opportunities for these people who go out to the rural
25 areas to keep up with the advances in your techniques;
26 the opportunities are there, and perhaps the only thing --
27 except perhaps a little bit more money -- is that there
28 must be some lack of incentive. The opportunities are
29 there; they can go and get their refresher courses. They
30 don't necessarily eventually become backward, and the same
thing applies to other things: nurses and doctors who
want to progress go to these places in order to keep up



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want to progress go to these places in order to keep up



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3 with the progress.

4 MR. DOERN: There is a difference in provi-
5 ding these refresher courses and the privilege of attending
6 the courses. These mean nothing unless you attend, and
7 there has been some difficulty getting these people to
8 attend. There is probably only one technician in the
9 area, and to let this technician come in for two or three
10 days, or a week, would practically throttle his or her
11 service to the institution. This is where we suggest
12 that the associate hospitals of Manitoba may step in.

13 COMMISSIONER BALTZAN: Are these refresher
14 courses expensive?

15 MR. DOERN: No, they are free.

16 COMMISSIONER BALTZAN: Is it within the
17 means of a substantial salary for an x-ray technician to
18 spare, or have anything left over, to be able to go to
19 your national convention or refresher course? Is the
20 salary sufficient enough to allow them to take advantage
21 of these opportunities that they have?

22 MR. DOERN: We don't think so. When you
23 speak of expense, there is, of course, the expense of
24 hotel accommodation and transportation back and forth;
25 that is, even from the rural area. As far as the actual
26 course is concerned, they are free; so far they have been
27 free. There has been no charge.

28 COMMISSIONER GIRARD: In many instances
29 wouldn't the hospital pay the expenses for such courses?
30 They do for other categories of employees at times in the
hospital.

MR. DOERN: They do in the larger hospitals.



MR. DORR: There is a difference in providing these refresher courses and the privilege of attending the courses. These mean nothing unless you attend, and there has been some difficulty getting these people to attend. There is probably only one technician in the area, and to let this technician come in for two or three days, or a week, would practically cripple his or her service to the institution. This is where we suggest that the associate hospitals of hospitals may step in.

MR. DORR: Is, they are free. COMMISSIONER KATZMAN: Is it within the means of a substantial salary for an x-ray technician to spare, or have anything left over, to be able to go to your national convention or refresher course? Is the salary sufficient enough to allow them to take advantage of these opportunities that they have?

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COMMISSIONER KATZMAN: In many instances wouldn't the hospital pay the expense for such courses? hospital



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3 and we hope they will in the smaller ones. Some smaller
4 ones may do it now; the Department of Health does pay for
5 some.

6 COMMISSIONER GIRARD: More or less going
7 to a refresher course is not a hardship. It is the
8 question of educational incentive on the part of the
9 student or of the technician?

10 MR. DOERN: That is right, but I still
11 come back to the same point that they apparently do not
12 all come in because of the shortage of someone to take
13 their place while they are away. This seems to be a
big problem.

14 THE CHAIRMAN: Thank you very much, gentle-
15 men.

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THE CHAIRMAN: Thank you very much, gentle-



SUBMISSION OF THE MANITOBA ASSOCIATION OF
REGISTERED NURSES

Appearances: Miss S. Nixon
Miss L. Pettigrew
Miss M. Cameron
Miss M. Maloney
Miss Williamson
Mrs. H. Mazerall
Mrs. Glass

--- EXHIBIT NO. 65: Submission of the Manitoba Association
of Registered Nurses.

MISS NIXON: Mr. Chairman and members of
the Commission: as President, I represent 3,800 members
of the Manitoba Association of Registered Nurses, which
was incorporated in 1913 by act of the Provincial Legis-
lature.

MANITOBA ASSOCIATION OF REGISTERED NURSES - BELIEFS

This statement of beliefs reveals, to some
degree, the basic concepts of members of the profession
in relation to their work and their personal welfare.

1. Society should be provided with health
service commensurate with its needs.
2. The care of the sick and the prevention
of illness are basic elements of our
culture.
3. Nursing is an essential component of
health services and the profession exists
to contribute its maximum potential to
health services.
4. It is the responsibility of governments,
national, provincial and local, to ensure



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4 that health services equal in quantity and
5 quality are provided for all people.

6 5. All persons engaged in health care
7 should receive an education commensurate
8 with the functions and responsibilities
9 they are to assume.

10 6. The education of nurses should be
11 provided in institutions whose primary
12 purpose is education.

13 7. Financial impediments to the acquisi-
14 tion of education for nursing should be
15 removed.

16 8. The acquisition of new knowledge
17 (research) is essential to a profession
18 serving a dynamic society.

19 9. The biological role of women is not a
20 deterrent to the education and employment
21 of women in our culture.

22 10. The remuneration of all health workers
23 should reflect the value of their service
24 to society.

25 RECOMMENDATIONS

26 It is recommended that:

27 1. The participation by many categories
28 of workers in the provision of nursing services should be
29 studied in detail in respect to:

- 30 (a) the effect on the quality and quantity
of nursing care given to patients;
(b) the total cost of nursing services;
(c) the disparity in salary differentials



- that health services equal in quantity and quality are provided for all people.
5. All persons engaged in health care should receive an education commensurate with the functions and responsibilities they are to assume.
6. The education of nurses should be provided in institutions whose primary purpose is education.
7. Financial impediments to the acquisition of education for nursing should be removed.
8. The acquisition of new knowledge (research) is essential to a profession serving a dynamic society.
9. The biological role of women is not a deterrent to the education and employment of women in our culture.
10. The remuneration of all health workers should reflect the value of their service to society.

It is recommended that:

1. The participation by many categories of workers in the provision of nursing services should be studied in detail in respect to:
 - (a) the effect on the quality and quantity of nursing care given to patients;
 - (b) the total cost of nursing services;
 - (c) the disparity in salary differentials;



on the basis of qualification and responsibilities. (Reference - P.17)

2. A study be made to define the functions of all categories of workers engaged presently in health services. (Reference - P.17)

3. To reduce the confusion in the classification of the many categories of health workers (which differs from one institution or agency to another, and from province to province) a classification guide be prepared which could be used throughout Canada. (Reference - P.17)

4. Expansion of rehabilitation and home care services should be provided:

(a) as a part of rehabilitation programmes greater provision should be made for convalescent care as well as long-term care;

(b) as a necessary component of home care programmes, homemaker services should be provided. (Reference - P.18)

5. A provincial advisory body, composed of citizens with broad experience and intellectual ability be established to provide an impartial consultative and advisory service to government and non-government organizations in the planning and co-ordinating of health services. (Reference - P.19)

6. Financial support for continuing professional education be maintained and extended. (Reference - P.19)

7. Nurses should be educated in



on the basis of qualification and responsi-

bilities. (Reference - P.17)

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professional education be maintained and extended.

6. Nurses should be educated in



institutions whose primary purpose is education. (Reference - P.20)

8. Financial support for nursing education should be provided. (Reference - P.20)

9. A baccalaureate degree program in nursing be established at the University of Manitoba without delay. (Reference - P.22)

10. In the planning of educational programmes for nursing personnel there should be close co-operation and consultation between the employers of nursing personnel and the agencies engaged in the preparation of all categories of nursing personnel. (Reference - P.23)

11. A study be made of the type of institutions which could best provide the types of education required by health workers (the many types of technicians, sanitarians, orderlies, practical nurses, professional nurses, etc.) of the future. (Reference - P.23)

12. A study be made of the costs of educational programmes presently conducted by all types of hospitals (general, psychiatric, rehabilitation, long-term care, etc.) (Reference - P.23)

13. The conditions and terms of employment for nurses should be commensurate with the functions and responsibilities they assume. (Reference - P.26)

We submit this, Mr. Chairman, and will welcome any questions the Commission may wish to present to us.

THE CHAIRMAN: Thank you very much, Miss Nixon. Is there anything that any other member of the



institutions whose primary purpose is education. (Reference - P.20)

8. Financial support for nursing education should be provided. (Reference - P.20)

9. A baccalaureate degree program in nursing be established at the University of Manitoba without delay. (Reference - P.21)

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13. The conditions and terms of employment for nurses should be commensurate with the functions and responsibilities they assume. (Reference - P.24)

We submit this, Mr. Chairman, and will welcome any questions the Commission may wish to present.

THE CHAIRMAN: Thank you very much, Miss

is there anything that any other member of the



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3 delegation would want to add at this time? I think your
4 brief gives those figures just for the purpose of discus-
5 sion; how many nursing schools have you in the province?

6 MISS NIXON: We have seven.

7 THE CHAIRMAN: And of those most are in
8 Winnipeg?

9 MISS NIXON: Six in Winnipeg and one in
10 Brandon.

11 THE CHAIRMAN: And you graduate how many
12 nurses a year?

13 MISS PETTIGREW: Around 300 to 350.

14 THE CHAIRMAN: That is a three-year course?

15 MISS NIXON: Yes.

16 THE CHAIRMAN: And the entire program is
17 carried on within the nursing school?

18 MISS NIXON: With some affiliating agencies.

19 THE CHAIRMAN: Are you familiar with the
20 centralized teaching program that has been going on in
21 Saskatchewan?

22 MISS NIXON: Yes.

23 THE CHAIRMAN: Have you anything similar
24 to that in Manitoba?

25 MISS NIXON: No, we have not.

26 THE CHAIRMAN: There has been no experiment
27 on that basis?

28 MISS NIXON: No.

29 THE CHAIRMAN: That naturally brings us to
30 your recommendation that the education of nurses should
be provided in institutions whose primary purpose is
education. Now, that excludes hospitals because their



delegation would want to see at this time? I think your
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THE CHAIRMAN: And of those seven are in

Winnipeg?

MISS NIXON: Six in Winnipeg and one in

Brandon.

THE CHAIRMAN: And you graduate how many

nurses a year?

MISS PELLERIN: Around 500 to 550.

THE CHAIRMAN: That is a three-year course?

MISS NIXON: Yes.

THE CHAIRMAN: And the entire program is

carried on within the nursing schools?

MISS NIXON: With some affiliating agencies

THE CHAIRMAN: Are you familiar with the

centralized teaching program that has been going on in

Saskatoon?

THE CHAIRMAN: Have you anything similar

to that in Manitoba?

MISS NIXON: No, we have not.

THE CHAIRMAN: There has been no experiment

on that basis?

MISS NIXON: No.

THE CHAIRMAN: That naturally brings us to

your recommendation that the education of nurses should

be provided in institutions whose primary purpose is

education. Now, that excludes hospitals because their



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3 primary purpose is looking after the sick. You mean to
4 take nursing schools, under this recommendation, away
5 from the hospitals?

6 MISS NIXON: That may not necessarily be
7 so, there might be a school independent of the hospital
8 organization which was still in close relation to the
9 hospital but not directly as a part of the hospital
service organization.

10 THE CHAIRMAN: Is that achieved through
11 a separate budget?

12 MISS NIXON: Partially, yes.

13 THE CHAIRMAN: Can it not be achieved
14 principally from a separate budget, a separate Director
15 of Nursing?

16 MISS NIXON: It might depend to some
17 extent on how the budget was provided for, that is where
18 the monies came from, if they are coming from the Hospital
Board.

19 THE CHAIRMAN: The hospitalization in the
20 year 1962 comes from the hospitalization program sponsored
21 by the Dominion and Provincial program and there is no
22 other source for money or is there any other source that
23 you know of?

24 MISS NIXON: At the present time, no.
25 This does not mean that we necessarily like it this way.

26 THE CHAIRMAN: You graduate approximately
27 350 nurses a year and that means that you have roughly
1,000 to 1,100 students in residence from year to year?

28 MISS NIXON: Yes.

29 THE CHAIRMAN: So if you were going to have
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4 separate educational institutions you would have to
5 provide for classroom accommodation and so forth?

6 MISS NIXON: Classroom accommodation,
7 yes.

8 THE CHAIRMAN: For 1,100 students. In
9 this atmosphere of detached educational institutions
10 how far would you be removed? I am not talking physically,
11 I am talking in terms of the professional connection from
12 the hospital to the nursing school.

13 MISS NIXON: I do not think any relationship
14 has at the present moment been planned at all because
15 there has been no prospect of such a program.

16 THE CHAIRMAN: That is so but you are
17 putting this forward as a serious suggestion, I take it?

18 MISS NIXON: We are not suggesting that
19 the student should not receive experience in hospitals
20 in the course of their education.

21 THE CHAIRMAN: I do not suggest that
22 either but you are putting forward a suggestion that
23 the education of nurses should be provided in an institu-
24 tion whose primary purpose is education and that naturally
25 is some other institution than the hospital.

26 MISS NIXON: Yes.

27 THE CHAIRMAN: What do you envisage in
28 that context as the relationship between the school and
29 the hospital or any relationship?

30 MISS NIXON: I think perhaps the Chairman
of our Educational Committee is more prepared to answer
this.

MISS CAMERON: Mr. Chairman, I believe

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MISS CAMPBELL: Now Chairman, I believe



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3 that what we are indicating here is that a school of
4 nursing should be a school and that the student should go
5 to the hospital when they require education and they
6 should not be used in the hospital for service. Student
7 nurses in the modern educational programs are being used
8 for service over and above what they require for their
9 basic education. If the school of nursing was on a
10 separate budget and the students were just in the hospital
11 for the education which they required then we would
12 consider the school an educational institution even
13 though it was associated with the hospital.

14 COMMISSIONER BALTZAN: Is that service
15 actually not educational?

16 MISS CAMERON: In some cases it is over
17 and above the education they require. For instance, as
18 an example, a student can look after someone who has had
19 their appendix removed and probably after taking care of
20 ten patients she knows how to take care of a patient
21 post-operatively of an appendix. But they keep on taking
22 care of them day after day and she make take care of 150
23 and she does not need that experience to know how to take
24 care of them. That is the way the hospitals use them
25 for service.

26 THE CHAIRMAN: That is necessarily so,
27 as you say, but in the school that you advocate for the
28 future, would students pay for tuition?

29 MISS CAMERON: That has been considered
30 to some degree and has been practised in many places,
students are paying tuition for the theoretical lectures
which they get the same as if they went to the University.

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4 compensated for the service which they provide which
5 levels off the cost to some extent.

6 THE CHAIRMAN: And, of course, their room
7 and board?

8 MISS CAMERON: Board, room and laundry is
9 provided at the present time. This would, of course, be
10 part of the salary that would be paid to the students
11 commensurate with service.

12 THE CHAIRMAN: The matter of being paid
13 for service and repaying it for board and room and
14 laundry ---

15 MISS CAMERON: We figure at the present
16 time approximately 50% of student time is spent in the
17 care of a patient and 50% of the time is spent in class
18 and clinics with regard to her education.

19 THE CHAIRMAN: In Manitoba a probationer
20 enters the school and how long is it before that proba-
21 tioner goes on the ward floor?

22 MISS CAMERON: Well, it depends on the
23 degree that you mean. In some schools they start in the
24 third week, some not till the ninth week and it is for a
25 very short period. The practice of pre-clinic period
26 runs from anywhere from 20 to 24 weeks in Manitoba.

27 THE CHAIRMAN: You have not got the rule
28 of a minimum of six months?

29 MISS CAMERON: We have a shorter period,
30 20 to 24 weeks and then most of the nurses in Manitoba
are running what we call a partial block system where
the students are in the wards for three days a week and

When they are gaining experience in the hospital they are compensated for the service which they provide which levels off the cost to some extent.

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4 first year they do not give much service to the hospital.
5 In the second and third year they give service to the
6 hospital so in the first year it is mostly educational
7 which they are not paying for.

8 THE CHAIRMAN: Are you familiar with the
9 survey that was made in a number of selected hospitals
10 to evaluate this very thing we are talking about, the
11 contribution of the nurse in terms of what the hospital
12 gets from the nurse?

13 MISS CAMERON: I do not know the study you
14 are referring to.

15 THE CHAIRMAN: It was about 1955.

16 MISS CAMERON: Miss Girard is shaking her
17 head as if I should know but I do not. The pilot project
18 I am very familiar with that but I did not think that was
19 completely the purpose of it.

20 THE CHAIRMAN: Did not Miss Schmidt make
21 the survey and the survey that was made for the Kellogg
22 people?

23 COMMISSIONER GIRARD: That was a partial
24 one, that was not national.

25 THE CHAIRMAN: It was made in Saskatchewan
26 prior to the centralized teaching program.

27 MISS CAMERON: Was that the one in regard
28 to costs?

29 THE CHAIRMAN: Yes.

30 MISS CAMERON: I am familiar with that.

THE CHAIRMAN: And rightly or wrongly, I
do not put this forward as a dogmatic statement that the



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4 conclusion was that the thing just about balances out
5 equally; the hospital would be just as well off if they
6 employed full-time graduate nurses and paid them full
7 salaries, just as well off as they are now with training
8 students but we would have no trained nurses on that
9 basis.

10 MISS CAMERON: I think there was a study
11 done in Michigan where they found out that it cost them
12 almost \$100 a month to educate a nurse over and above
13 what they gave her for board and room.

14 THE CHAIRMAN: That was part of the Kellogg
15 Survey because they operate out of Battle Creek, Michigan.

16 COMMISSIONER GIRARD: I would like to go
17 back to the beginning of this discussion and I think we
18 started off on the premise that the school should be an
19 educational institution; the hospital is not an educational
20 institution, therefore, the hospital school cannot be an
21 educational institution. Is this right? We started off
22 somewhat like this and I think if we go back to the pilot
23 project which is sort of our Bible in the last couple of
24 years we will find that 16% - it is a small percentage -
25 16% of the schools were very good because the accredita-
26 tion criteria was very high. Therefore, this to my know-
27 ledge has demonstrated that a hospital school can be a
28 good educational institution. I do not know if you agree
29 with that?
30

MISS CAMERON: I think that I would have
to agree because the accrediting committee said 16% of
them were very good. I think if you are familiar with
the schools, they had a very high percentage of instructors



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4 COMMISSIONER GIRARD: The point I am trying
5 to make is that the hospital school, although not prima-
6 rily a hospital, not being primarily an educational
7 institution, can be a good educational institution. The
8 hospital school can be provided it has the proper instruc-
9 tional set-up. This is what I wanted to rectify because
10 I think we started off on the premise that the hospital
11 school could not be a good educational institution.

12 THE CHAIRMAN: I do not know who started
13 off with that but I didn't.

14 COMMISSIONER GIRARD: I seem to get this
15 implication that it should be a good educational institu-
16 tion and the hospital is not; is that not it?

17 THE CHAIRMAN: Oh, no.

18 COMMISSIONER GIRARD: Well then, I was
19 wrong. I think the hospital school can be a good educa-
20 tional set-up, we have proven that.

21 MISS CAMERON: Of the schools accredited
22 16 were schools with a very high percentage of instruc-
23 tional staff and the cost to the hospital was considerably
24 higher and this cost is borne by the patient.

25 COMMISSIONER GIRARD: It was some years
26 ago borne by the patient, was it not?

27 MISS CAMERON: It is still borne by the
28 patient to some degree by the public paying their hospital
29 premium.

30 COMMISSIONER GIRARD: We talk about indepen-
dent schools because we want schools to be educational
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4 MISS NIXON: I think we would agree with
5 that providing there are safeguards to protect the educa-
6 tion of the student.

7 COMMISSIONER GIRARD: That is right. Then
8 we do agree on this point. On page 5, No. 2, you say:

9 "A study be made to define the functions
10 of all categories of workers engaged
11 presently in health services".

12 You want a study on functions. Do you
13 feel that we have had so far some studies on functions
14 that have proven something?

15 MISS NIXON: I think perhaps in limited
16 areas. We are concerned, as you have heard from other
17 briefs, about the supply of health workers, not only in
18 nursing but in all the various sections of health services.
19 This has, I think, tended to produce a situation where
20 nurses in particular are assuming functions for which
21 they are not prepared and which require varying lengths
22 of specified education to produce a qualified worker.
23 We have instances in this province where nurses are doing
24 lab. work, taking x-rays, even, unfortunately, administering
25 anaesthetics and we do not feel they are prepared to do
26 this. However, unless some category of functions is set
27 up it can still be assumed that because the nurse is there
28 she is competent to do it and this is still the assumption
29 in some areas.

30 COMMISSIONER GIRARD: What you say in this
province is true of many provinces, nurses after 6 o'clock
or after 5 o'clock become pharmacists, become pretty well



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5 alone will give us what we need or are you of the opinion
6 that studies in utilization after study in function would
7 tend to help us in getting the nurse to do what she is
8 supposed to be doing?

9 MISS NIXON: Perhaps a study of utilization
10 would help to define the functions but if you are going
11 to establish educational programs you require to know and
12 if you know the function a person is to perform you can
13 design a better educational program.

14 COMMISSIONER GIRARD: Well, one would go
15 with the other?

16 MISS NIXON: Yes.

17 COMMISSIONER GIRARD: So should you have
18 only one or two if you want to get positive results? Do
19 you believe a study in utilization is necessary?

20 MISS NIXON: I think it would be most
21 helpful, yes.

22 COMMISSIONER GIRARD: In paragraph 6 you
23 speak of financial support and in what form do you fore-
24 see financial support and for what categories or at what
25 levels?

26 MISS NIXON: We are concerned at the
27 present time, the bursary assistance available is applied
28 mainly to the lower levels of post-basic education, that
29 is, a doctor's certificate or perhaps as far as a
30 Bachelor's degree. We have very few instances in which
support is provided for the Master's level, specialized
levels and the doctor level of education. We do feel



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5 suffering from a very serious lack of people prepared at
6 the really high levels and this is being reflected, I
7 think, in the number of institutions, large institutions
8 in the country who cannot obtain people for the higher
9 administrative supervisory and teaching positions.



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3 THE CHAIRMAN: I suppose that personnel
4 must come from the University school?

5 MISS NIXON: Yes. Maybe not primarily.
6 Most of our present ones have been prepared in hospital
7 nursing schools, then have gone into University.

8 THE CHAIRMAN: Yes, but for the future
9 that may well be the essential function of the University
10 school?

11 MISS NIXON: Yes, it would save a great
12 deal of time if they start there, because usually we
13 find there is a great amount of catching up to do in
14 general education and general information, if they have
15 started in a narrow, specialized ---

16 COMMISSIONER BALTZAN: Under the present
17 curriculum, including the hospital service portion as I
18 mentioned before and which you answered, could you tell
19 me what do the students' daily learning and working hours
20 total up to under the present system?

21 MISS NIXON: It is a 40-hour week at the
22 present time.

23 COMMISSIONER BALTZAN: One other thing,
24 you mentioned that you have so many hospitals in Manitoba.
25 Are there any other areas with sufficient enough hospital
26 beds that could have developed alongside it, or have
27 built into it another school for nurses?

28 MISS NIXON: Not at the present time.
29 There are other hospitals which may be developing an
30 adequate number of beds, but they are not in operation
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COMMISSIONER STRACHAN: What is considered



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3 an adequate number?

4 MISS NIXON: Well, our legislation says
5 50 beds, but we do not consider that this is in any way
6 adequate to support a school of nursing.

7 THE CHAIRMAN: Is it intended that the
8 projected hospital in St. James will have a nursing
9 school?

10 MISS NIXON: The proposal for this hospital,
11 sir, is that it will be a move for the existing Grace
12 Hospital, which has a school at the present time.

13 THE CHAIRMAN: I mean, the new hospital
14 is projected for what, about 350 beds?

15 MISS NIXON: Yes, but that has a school
16 at the present time, and we assume that the school would
17 move with it.

18 COMMISSIONER STRACHAN: If you are able
19 to eliminate this repetitious service referred to, repeti-
20 tious service or experience, could the training time of
21 a nurse be reduced?

22 MISS NIXON: I think this has been proven
23 sir in experiments that have taken place. We in Manitoba
24 might not wish to approach it in this way. We might
25 prefer to use the additional time by broadening the
26 students' experience. I cannot say which way it would
27 go.

28 COMMISSIONER McCUTCHEON: You are referring
29 to the Winchell experiment?

30 MISS NIXON: Yes.

THE CHAIRMAN: In this broad experience,
do you contemplate a term, say, in a mental institution,



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MISS NIXON: Yes, but that has a school at the present time, and we assume that the school would move with it.

COMMISSIONER STRACHAN: If you are able to eliminate this repetition of service referred to, necessary service or experience, could the training time of a nurse be reduced?

MISS NIXON: I think this has been proven in experiments that have taken place. We in Manitoba might not wish to approach it in this way. We might prefer to use the additional time by increasing the students' experience. I cannot say which way it would

go.

COMMISSIONER MCDONALD: You are referring to the Mitchell experiment?

THE CHAIRMAN: In this broad experience, do you contemplate a term, say, in a mental institution



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3 or nursing in some other institution beyond the parent
4 hospital?

5 MISS NIXON: Yes, we have been very anxious
6 to embody this as a requirement in our education, as Dr.
7 Pincock, I believe, mentioned yesterday. Up to the
8 present time, while clinical material has been in adequate
9 supply, we have not found that the mental hospitals have
10 been able to provide enough, either in educational person-
11 nel or in supervisory personnel, to enlarge their programs
12 for the students in the province. We are re-writing our
13 legislation at the present time, and I can assure you
14 that this may very well become a requirement, but quite
15 apart from that we would like to see our students more
16 aware of the social and public health areas of nursing,
17 and feel that they require more experience for the care
18 of people, rather than just patients in hospitals.

18 THE CHAIRMAN: Is it possible to work out
19 a rotation in public health nursing?

20 MISS NIXON: Perhaps I should refer this
21 to Miss Williamson, who is in public health nursing.

22 MISS WILLIAMSON: At the present time, sir,
23 we have senior students from three of the hospitals in
24 Winnipeg having two weeks with the Provincial Department,
25 and I believe one of the other hospitals has affiliation
26 with the City Health Department and with the V.O.N.

27 THE CHAIRMAN: For two weeks? I mean,
28 your program is two weeks?

29 MISS WILLIAMSON: Ours is two weeks.

30 THE CHAIRMAN: That is a rather short
rotation, is it not?

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4 MISS WILLIAMSON: We have also had
5 requests from other hospitals, but so far we haven't
6 taken the students out of the Greater Winnipeg area for
7 this type of work, and we are therefore limited as to the
8 areas which we have been able to use.

9 THE CHAIRMAN: What would be the length of
10 the rotation that would be regarded as a satisfactory
11 period? I mean, as a more satisfactory period than two
12 weeks?

13 MISS WILLIAMSON: Well, I would like to
14 see them have three months, but I think one month isn't
15 very long.

16 COMMISSIONER STRACHAN: If you train
17 nurses in an institution whose primary purpose is educa-
18 tion, may I presume that they would all in this province
19 at least, all have to be trained in one institution?
20 Would those students get their practical training in one
21 hospital, or still in schools, or several hospitals of
22 the province, and I might add further to that question,
23 what proportion of time do you envisage in this institu-
24 tion and in hospital training?

25 MISS NIXON: This we don't know at the
26 present time sir. We are hoping that the results of the
27 study which is being carried on by the Canadian Nurses'
28 Association will give us some guidance in the type of
29 education program which may provide nurses better prepared
30 for nursing service than we feel that we are providing at
the present time.

THE CHAIRMAN: That is Dr. Negley's?

MISS NIXON: Yes. We are anxiously

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4 awaiting this study, because we feel that this would be
5 a very much more valid thing than anything we can do
6 ourselves in just a small province.

7 COMMISSIONER STRACHAN: This idea then is
8 still in an embryonic stage?

9 MISS NIXON: Oh yes, but then this
10 Commission is not just looking at tomorrow, is it?

11 COMMISSIONER STRACHAN: This has not been
12 tried out in any part of the world before?

13 COMMISSIONER VAN WART: Are you familiar
14 with the Kellogg scheme, which is going on in the Univer-
15 sity of New Brunswick at the present time?

16 MISS NIXON: Yes.

17 COMMISSIONER VAN WART: They are in their
18 third year now of their degree course, and these girls
19 take their clinical training in five, six, or seven
20 hospitals, and they get their medicine in one, obstetrics
21 in another, surgery in another, and so on, and it is
22 working out very satisfactorily.

23 MISS NIXON: I would anticipate sir that
24 whoever is directing such a program would select the
25 experiences as they were available, according to both the
26 number of students, the clinical material in the different
27 hospitals, providing the hospitals wish to accept the
28 students, and would also select them according to the
29 quality of the nursing care, particularly in that hospital.

30 COMMISSIONER VAN WART: The University
supervisors go right into the hospitals, and the girls
are assigned so many patients, and that is all the work
it is. There is no work required by the hospital at all.

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4 COMMISSIONER FIRESTONE: May I refer to
5 paragraph 4 on page 3 of your summary. You say that it
6 is the responsibility of governments, national, provin-
7 cial, and local, to ensure that health services equal in
8 quantity and quality are provided for all people. Does
9 this paragraph mean that the Manitoba Association of
10 Registered Nurses is in favour of a prepaid, comprehensive
11 health care service program, on a universal scale,
12 including nursing services?

13 MISS NIXON: Yes.

14 COMMISSIONER FIRESTONE: Do you realize,
15 Miss Nixon, that if such a program were to be implemented,
16 that this may require a significant increase in the
17 supply of nurses in Manitoba?

18 MISS NIXON: We are very well of this sir,
19 and we would state we do not believe that any program
20 should be implemented overnight. In fact, not only so
21 far as nurses are concerned. We feel that if any program
22 is to be instituted in the future, the first necessity
23 is the preparation of all areas of health personnel.

24 COMMISSIONER FIRESTONE: I take it from
25 what you say that you realize this growing requirement,
26 assuming that there is an expanded program ahead, and
27 therefore there will be the need to attract more young
28 people into the nursing profession. Have you any specific
29 suggestions to make to this Commission as to what could
30 be done to attract more young women into the nursing
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MISS NIXON: I think this is very difficult,



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3 sir, because all fields are trying to attract more of
4 the level of, shall we say, the better-prepared high
5 school student, into their professions. To some extent
6 we do feel that in comparison with the other professions
7 requiring as long a period of preparation, that the
8 financial rewards in nursing are not equivalent, but we
9 do not feel that all nurses, or prospective nurses are
10 deterred because of this.

11 COMMISSIONER FIRESTONE: We realize your
12 difficulty, Miss Nixon. On the other hand, this Commis-
13 sion in making recommendations to the Government, must
14 have proposals from people who are familiar with the
15 particular problem, and you have made a number of general
16 observations about the problem, and what might be done
17 about it. Can you help the Commission by giving first
18 consideration to specific proposals that would assist
19 the nursing profession, or would assist the Province of
20 Manitoba to attract more young women into the nursing
21 profession, and let us have this information in writing
22 at a subsequent time?

23 MISS NIXON: We will.

24 COMMISSIONER McCUTCHEON: The real problem
25 is not how you entice them into the profession, but how
26 you keep them there.

27 MISS NIXON: This is very true sir, and
28 we also feel that one of the problems is an unrealistic
29 presentation to them in the first place, that many girls
30 think they would like to come into nursing, and when they
do find it is not what they expect and leave it to go
into something else.

...the Commission is not a school student, into their professions. To some extent we do feel that in comparison with the other professions regarding as long a period of preparation, that the financial rewards in nursing are not equivalent, but we do not feel that all nurses, or prospective nurses are deterred because of this.

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4 COMMISSIONER FIRESTONE: Well, following
5 up what Commissioner McCutcheon has suggested, I take it
6 in this supplementary material you are supplying us you
7 might include some comments of how married women might
8 again be brought back into the nursing profession at
9 some stage sooner or later, because the supply does not
10 necessarily consist of young people going into the
11 nursing profession and getting their training, but you
12 might also gain by persuading experienced nurses who are
13 married and may have time and inclination to return, so
14 can we have your comments on this broader supply position,
15 rather than young people entering the profession?

16 MISS NIXON: Yes, we have felt in the last
17 few years sir, that a very large proportion of the
18 increase in the number of nurses we have registered in
19 Manitoba has definitely come from the married group. At
20 the present time 53.3% of our practising nurses are
21 married.

22 COMMISSIONER FIRESTONE: So you are offering
23 some comfort to Commissioner McCutcheon?

24 MISS NIXON: Well, I don't know. Perhaps
25 he feels that we should do better. We cannot stop them
26 getting married.

27 COMMISSIONER FIRESTONE: On the same
28 subject, are there any registered male nurses in the
29 Province of Manitoba?

30 MISS NIXON: Yes, there are. How many are
there, Miss Pettigrew?

MISS PETTIGREW: I believe at the present
time there are about 18 or 19 practising here. They are

up what Commissioner Johnston has suggested, I take it in this supplementary material you are supplying us you might include some comments of how married women might again be brought back into the nursing profession at

some stage sooner or later, because the supply does not necessarily consist of young people going into the

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4 all graduates from other provinces, and this year in
5 1962 we will see the first two graduates of the Winnipeg
6 school.

7 COMMISSIONER FIRESTONE: Could you also
8 include in your proposals suggestions as to how you
9 could encourage more males to enter the nursing profession?
10 What I have in mind is, as our health service program
11 expands, we may have to rely not only on the ladies, but
12 also on more males in the various health professions,
13 and since Canada has had a problem with unemployment, if
14 more expenditures were made in the health field, and more
15 males as well as females were to find employment in the
16 field, we would achieve both. So could we have your
17 comments on this particular point as well in a supplemen-
18 tary submission?

19 MISS NIXON: We will do that sir.

20 COMMISSIONER FIRESTONE: Are there available
21 in the Province of Manitoba adequate facilities for
22 nursing residences?

23 MISS NIXON: This is a question which is
24 being studied at the present time by the Manitoba Hospital
25 Survey Board in its survey of personnel. We are hoping
26 they will give us some information about this.

27 COMMISSIONER FIRESTONE: Would it be
28 possible for you in the supplementary material you will
29 be making available to the Commission to make some obser-
30 vations about the facilities that are presently available,
and what improvements you would recommend. Presumably
nurses' residences are one of the important requirements
to make it easier for young people to go into the nursing

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profession, and it would help if we knew more about it.

MISS NIXON: Sir, we are not traditionalists in the thought that all students must live in residences.

COMMISSIONER FIRESTONE: I accept that, and I am very happy to learn that you have an open mind on all these matters, but presumably the subject of nurses' residences is a fairly important one, and if you could make available to the Commission whatever facts are available about nursing residences, and what could be done to improve existing facilities, this would be helpful.

MISS NIXON: May we await the Willink Report before we submit this, so that we will have their information?

COMMISSIONER FIRESTONE: We will entirely leave it to your good judgment when you may submit it, but we hope we will get it before this Commission submits its report.

MISS NIXON: It will be before that.

COMMISSIONER FIRESTONE: May I also suggest that in advising us about this state of affairs, you will also offer some comments as to whether loans under the National Housing Act have been used to build nursing residences in the Province of Manitoba, and if these loans have not been used, why not?

MISS NIXON: Do you mean students' residences?

COMMISSIONER FIRESTONE: Nurses' residences. I am not asking for an answer now.

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COMMISSIONER FIRESTONE: Nurses' residences



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4 MISS CAMERON: They have been used for
5 graduate nurses' residences, but not for students' resi-
6 dences.

7 COMMISSIONER FIRESTONE: You have made a
8 number of recommendations in this report, and presumably
9 you will be spelling out some of those recommendations
10 in a subsequent submission. The Commission would be
11 interested in you giving us the financial implications
12 of these various proposals. After all, it will cost
13 money to implement some of the things, and you will have
14 some ideas of what will be involved, and you could advise
15 us as to where, in your opinion, the money should come
16 from.

17 THE CHAIRMAN: Thank you very much Miss
18 Nixon and the ladies who are with you here this afternoon.
19 We have had a submission from the Registered Nurses'
20 groups in various provinces which have been regarded as
21 one of the important submissions, and we are indebted to
22 you for the time you put in the preparation of your
23 brief, and for your attendance here today.

24 We will adjourn until 9 o'clock tomorrow
25 morning, when we will proceed with our agenda.

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27 --- Adjournment.
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ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

WINNIPEG

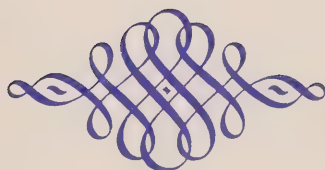
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VOLUME NUMBER :

15

DATE:

JANUARY 18 1962



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3 ROYAL COMMISSION ON HEALTH SERVICES
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5 Proceedings of the hearing
6 held in Winnipeg, Manitoba,
7 18th day of January, 1962.
8

9 COMMISSION MEMBERS:

10 CHIEF JUSTICE EMMETT M. HALL -- Chairman

11 MISS ALICE GIRARD, R.N.

12 DR. DAVID M. BALTZAN

13 PROF. O.J. FIRESTONE

14 MR. M. WALLACE McCUTCHEON, Q.C.

15 DR. C.L. STRACHAN

16 DR. ARTHUR F. VAN WART

17 COMMISSION COUNSEL:

18 MR. R.N. HALL, Q.C.

19 MEDICAL CONSULTANT:

20 DR. PIERRE JOBIN

21
22 DIRECTOR OF RESEARCH:

23 PROF. BERNARD BLISHEN

24
25 SECRETARY:

26 MAJ. N. LAFRANCE
27
28
29
30



Winnipeg, Manitoba,
Thursday,
January 18th, 1962.

--- On commencing at 9 a.m.

THE CHAIRMAN: Gentlemen, if you are
ready to proceed this morning, we will hear the submission
of the Winnipeg Chamber of Commerce.

SUBMISSION OF THE WINNIPEG CHAMBER OF COMMERCE

Appearances: Mr. G.R. Hunter, President
Mr. D. Kilgour
Mr. J.E. Morrison

--- EXHIBIT NO. 66: Submission of the Winnipeg Chamber
of Commerce.

MR. HUNTER: My Lord and members of the
Commission, on behalf of the Winnipeg Chamber of Commerce
I would like to express our pleasure at being able to
appear before you this morning. We have a delegation
from the Chamber, and, with your permission, if there
are any questions which become of a technical nature, or
of any other nature which I cannot answer, I would like
to be able to call on some of the rest of the delegates.

THE CHAIRMAN: Very well.

MR. HUNTER: My Lord and Members of the
Commission:

The Winnipeg Chamber of Commerce is an
association of business and professional men and women,
grouped together "for the common purpose of promoting the
commercial, financial, professional, educational and
social conditions of Greater Winnipeg in particular, and



Mr. J. H. Hunter, President

THE CHAIRMAN: Gentlemen, if you are

ready to proceed this morning, we will read the submission

Appointed: Mr. J. H. Hunter, President

--- EXHIBIT NO. 88: Submission of the Winnipeg Chamber
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grouped together "for the common purpose of promoting the
commercial, financial, professional, educational and
social conditions of Greater Winnipeg in health, and



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3 Manitoba and Canada in general".

4 In 1873, it was incorporated as The Winni-
5 peg Board of Trade by a Public Act of the Manitoba Legis-
6 lature. In 1879 it obtained a federal incorporation,
7 again under the name of The Winnipeg Board of Trade.
8 Under that name, and, in recent years, its present name
9 of The Winnipeg Chamber of Commerce, it has over the
10 years maintained a lively interest in all matters affect-
11 ing the business life of Greater Winnipeg. With a member-
12 ship of almost 2,000, representing some 1,400 businesses,
13 it provides a broad cross section of the business commu-
nity.

14 The Winnipeg Chamber of Commerce believes
15 that the attainment and preservation of good health
16 should be a primary objective for the Canadian people.
17 The members of the Chamber are advocates of free enter-
18 prise in a free society and believe that the individual
19 has the primary responsibility to make provision for and
20 to pay the cost of medical care for himself and his
family.

21 With these beliefs, the Chamber is pleased
22 that the terms of reference of the Royal Commission on
23 Health Services are such that all aspects of Canadian
24 health care and services are to be the subject of objec-
25 tive examination and study. Much worthwhile information
26 not otherwise available or forthcoming should be developed.

27 Despite the relatively broad terms of
28 reference, which we know the Commission will attack with
29 vigor, the Chamber is concerned that the popular view has
30 narrowed the terms to a consideration of whether or not



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4 Canada should have a universal health care plan operated
5 and financed - in whole or in part - directly by or under
6 the aegis of the government.

7 The Chamber trusts that the Royal Commis-
8 sion will:

9 1. Search out and define the real areas
10 of genuine need that may exist today in the availability
11 of health care, establishing whether or not there are:

12 (a) any areas in which, for lack of popu-
13 lation or for economic reasons, medical
14 care simply is not available within a
15 reasonable distance; and

16 (b) old people with minimum incomes
17 being required to pay medical costs that
18 can be met only by eliminating other essen-
19 tials of living;

20 (c) other than rare instances of true
21 hardship arising from medical expense,
22 (assuming continuation of the traditional
23 policy of the medical profession to treat
24 patients without means, for nominal fees,
25 or no fee at all).

26 2. Keep in the foreground the consequences
27 of the different courses of action which will be recommen-
28 ded - especially when such courses entail further invasion
29 by the government into the traditional fields of private
30 enterprise; and

3. Consider, in making any recommendations,
what costs will be added to an already high level of
government expenditures. Many Canadian industries are



Canada should have a universal health care plan covering all Canadians. The plan should be based on the principle of universal access to health care. The plan should be financed by a combination of government and private sources. The plan should be administered by a central authority. The plan should be subject to regular review and evaluation.

tion will:

1. Search out and define the real needs of genuine need that may exist today in the availability of health care, establishing whether or not there are:
 - (a) any areas in which, for lack of population or for economic reasons, medical care simply is not available within a reasonable distance; and
 - (b) old people with minimum incomes being required to pay medical costs that can be met only by eliminating other essential of living;
 - (c) other than rare instances of true hardship arising from medical expense, (assuming continuation of the traditional policy of the medical profession to treat patients without means, for nominal fees, or no fee at all).
2. Keep in the foreground the consequences of the different courses of action which will be recommended - especially when such courses entail further invasion by the government into the traditional fields of private enterprise; and
3. Consider, in making any recommendations what costs will be added to an already high level of government expenditures. Many Canadian industries are



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4 experiencing difficulty in developing foreign markets
5 where cost is a major factor. Any domestic action which
6 increases costs may handicap such firms to the extent
7 that the potential markets may be lost to others, with
8 consequent adverse effects at home.

9 THE CHAMBER'S POSITION

10 The Chamber urges serious and careful
11 consideration of the alternatives to a government-operated
12 and financed plan. Already more than 50% of the Canadian
13 population is insured through private plans to the extent
14 of their choice against health care costs. Today, any
15 resident of Manitoba can buy partial or full health care
16 from private insurers or medical service plans. The cost
17 of these plans vary with completeness of coverage. As a
18 continuing service, this cost will rise or fall depending
19 on experience, with the great advantage that the users
20 will be sensitive to and can influence the final costs.

21 It is not to be denied that there are
22 sectors of the population not insured against health care
23 costs. These are the group unable to meet present-day
24 underwriting standards, the group having no taxable
25 income and therefore deemed unable to pay for medical
26 care, and, finally, the group that does not choose to
27 insure, taking this as merely one of the many risks they
28 are prepared to meet. In Manitoba, substantial beginnings
29 already have been made in protecting the first two groups
30 in that the Medical Service Plan will accept anyone
regardless of age or condition while the "Medicare Plan"
is applicable to anyone in receipt of government assistance on a needs basis.

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THE CHAMBER'S POSITION

The Chamber urges serious and careful consideration of the various proposals for a national and financed plan. Already more than 50% of the Canadian population is insured through private plans to the extent that a national plan would be a duplication of effort. A resident of Manitoba can pay partial or full health care from private insurers or medical service plans. The cost of these plans vary with completeness of coverage, as a continuing service, this cost will rise or fall depending on experience, with the great advantage that the costs will be sensitive to and can influence the final costs. It is not to be denied that there are sectors of the population not insured against health care costs. These are the group unable to meet present-day underwriting standards, the group having no taxable income and therefore deemed unable to pay for medical care, and, finally, the group that does not choose to insure, taking this as merely one of the many risks they are prepared to meet. In Manitoba, substantial beginnings already have been made in protecting the first two groups in that the Medical Service Plan will accept anyone who is unable to meet the underwriting standards of private insurance is applicable to anyone in receipt of government assistance on a needs basis.



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4 The Winnipeg Chamber of Commerce has the
5 strong conviction that a universal government health care
6 plan is not in the best interests of the Canadian people.
7 We believe that government should concentrate on areas of
8 need rather than seek to tear down the valuable structure
9 carefully built on experience of the past and rapidly
10 growing at no cost to the government.

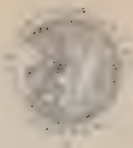
11 THE REASONS

12 This position is arrived at by considera-
13 tion of the problem from the five different aspects
14 below, which in the Chamber's judgment, all support the
15 conviction.

16 1. The quality and availability of medical
17 care;

18 This is controlled in large measure by the
19 medical profession. Their numbers, quality of training,
20 and devotion to their profession, are influenced not a
21 little by the incentives which exist to encourage a high
22 degree of excellence in medical care together with satis-
23 factory service to patients. We believe that to make such
24 a valuable service as medical care ostensibly free to the
25 user would result in a very great increase in the demand
26 for medical services with a consequent deterioration in
27 the care accorded those whose medical needs are greatest.

28 One of the most recent appraisals of the
29 British Health scheme, Dr. D.S. Lees' Hobart Paper
30 "Health Through Choice", reaches this conclusion - "...that
a monolithic structure financed by taxation is ill-suited
to a service in which the personal element is so strong,
in which rapid advances in knowledge require flexibility



The Winnipeg Chamber of Commerce has the strong conviction that a universal government health care plan is not in the best interests of the Canadian people. We believe that government should concentrate on areas of need rather than seek to tear down the valuable structure carefully built on experience of the past and rapidly growing at no cost to the government.

THE REASONS

This position is arrived at by consideration of the problem from the five different aspects below, which in the Chamber's judgment, all support the conviction.

1. The quality and availability of medical care;

This is controlled in large measure by the medical profession. Their numbers, quality of training, and devotion to their profession, are influenced not a little by the incentives which exist to encourage a high degree of excellence in medical care together with satisfactory service to patients. We believe that to make such a valuable service as medical care ostensibly free to the user would result in a very great increase in the demand for medical services with a consequent deterioration in the care accorded those whose medical needs are greatest.

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3 and freedom to experiment, and for which consumer demand
4 can be expected to increase with growing prosperity".

5 He further stresses the danger to both
6 the patient and doctor of political control "based on
7 short-period electoral calculations".

8 There is a further important consideration
9 and that is whether or not a government health care plan
10 with removal of the means test will improve the lot of
11 those in need of health care. Dr. Lees, in his "Health
12 Through Choice", observes, "There is a growing realiza-
13 tion, even among writers deeply opposed to a means test,
14 that those who have benefited most from the post-war wel-
15 fare state are those who have needed it least. If
16 resources had been concentrated on those in need, more
17 could have been done".

18 The Government must choose between various
19 responsibilities as well as various manners of spending
20 its limited income. The Chamber submits that Canada can
21 ill afford to expend money and resources for health care
22 for other than those in need.

23 2. The lack of need for government intru-
24 sion:

25 The point has been made frequently that
26 food, shelter and clothing are far more fundamental to
27 human existence than medical care. Governments have
28 wisely concluded that these essentials must be an indivi-
29 dual responsibility for all but the clearly needy.

30 The dramatic increase in coverage arranged
through private insurers and medical service plans
already constitute a giant stride in protecting the public

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4 against severe fluctuations in health costs. These plans
5 operate without state subsidy and intervention and can
6 be expected to continue to improve and broaden their
7 services.

8 Speaking to the United States proposals for
9 medical care for the aged, Republican National Chairman
10 William E. Miller said recently, "We can find an analogy -
11 which is not far-fetched - in plans for slum clearance
12 in our major cities. We all want to see slums eradicated
13 ...but who in his right mind would suggest that, in order
14 to rid this city of slum areas, we ought to tear down the
15 Empire State Building, the U.N. Headquarters, the apart-
16 ments and hotels along Central Park, and hundreds of
17 thousands of comfortable homes already standing - and
18 then rebuild from scratch?"

19 In the Chamber's judgment, this is precisely
20 what state medical schemes propose to do in Canada.

21 3. The inevitable increased costs of a
22 universal government plan:

23 The Commission need only to look to
24 experience with the recently introduced hospital plans
25 for an example of increased costs which are inevitable.
26 Cost estimates have been widely exceeded and the current
27 annual bill much in excess of half a billion dollars
28 grows with alarming regularity. Increased costs are
29 inevitable in a government plan because of the essential
30 uniformity called for and the unavoidable rules and
regulations that must be drawn up and administered. With
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3 personal incentives, further increased costs will be
4 inevitable.

5 4. " The effect on the Medical Profession:

6 As traditional exponents of the merits of
7 enterprise, initiative and personal responsibility, we
8 are deeply concerned that any state scheme, no matter how
9 palatable on the surface, must inevitably result in the
10 medical profession becoming another arm of the government
11 service. When the government monopolizes medical services,
12 it must also accept the responsibility for regulation,
13 remuneration and allocation of the individuals who alone
14 can supply medical care.

15 We foresee several grave dangers:

16 (a) A loss of freedom to use individual
17 judgment, as well as increased regimenta-
18 tion, both of which will stifle and
19 frustrate many of our most talented doctors;

20 (b) The movement of many able men to the
21 United States, or other countries without
22 such plans to the end that we have less
23 medical care, not more;

24 (c) A deterioration in the quality and
25 numbers of men taking medical training
26 with a continuing impact which cannot be
27 calculated; and

28 (d) A continuing series of pressures
29 between government, the medical profession,
30 patients and politicians which will be
harmful to all concerned, and detract
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sick.

We do not seek to defend the "status quo" as being without room for improvement. Current problems, shortcomings and abuses should be faced up to and intelligently attacked. But it is neither necessary, nor desirable, to conscript an entire profession in order to provide increased services and medical care for those in need.

5. Effect on the Canadian Economy:

As an exporting nation faced with increasingly competitive conditions, Canada must do everything possible to keep present costs from rising and certainly, wherever possible, to avoid incurring new structural costs - either in the private or public sector. If new structural costs are incurred or imposed by government, such costs would have to be financed by increased taxation or by deficit borrowing. Deficit borrowing encourages inflation and taxation is already high.

It has been estimated that the cost of adding a national medical care plan to existing government spending in the health field, would raise the total of such spending by all governments by 33% or to over 1.1/2 billion dollars - a sum almost equal to the present total of personal income taxes and well in excess of total corporate taxes.

The Chamber has continually exhorted business and labor to exercise restraint in negotiating structural wage changes. It is consistent now for the Chamber equally to exhort government to avoid new costs which might impair Canada's competitive trade position.



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4 CONCLUSION

5 In the light of the serious disadvantages
6 of any universal government health care plan, The Winnipeg
7 Chamber of Commerce submits that it would be unwise to
8 abandon the voluntary system of insurance or prepayment
9 of the cost of health care presently supported by more than
10 half of the citizens of Canada - a system which operates
11 effectively, efficiently and at no cost to government at
12 any level but, in fact, is a source of revenue to govern-
13 ment.

14 It is the view of the Chamber that the full
15 support and efforts of governments, voluntary agencies
16 and free enterprise should be directed toward meeting
17 the challenge of uncovered areas - uninsurables by present
18 standards and groups without the means to pay for health
19 care. Surely the efforts of all directed towards meeting
20 the needs of this comparatively small segment of our popu-
21 lation would ensure the availability of adequate medical
22 care for all Canadians.

23 Many proposals will be recommended to the
24 Commission as to the manner in which the needs of the
25 citizens in the field of health care can best be met.
26 There will be various compromise proposals lying between
27 two basic choices - first, that government resources
28 should be devoted exclusively to areas of need only and
29 with the great majority of citizens left free to meet
30 their health needs in a competitive free economy without
assistance or subsidy - and second, that there should be
a universal compulsory plan without choice and financed
in whole or in part by Government revenues. The Chamber

in the light of the serious disadvantages of any universal government health care plan. The Winnipeg Chamber of Commerce submits that it would be unwise to abandon the voluntary system of insurance or reinsurance on the cost of health care presently supported by more than half of the citizens of Canada - a system which operates effectively, efficiently and at no cost to government at any level but, in fact, is a source of revenue to government.

It is the view of the Chamber that the full support and efforts of governments, voluntary agencies and free enterprise should be directed towards meeting the challenge of uncovered areas - unmet needs by present standards and groups without the means to pay for health care. Surely the efforts of all directed towards meeting the needs of this comparatively small segment of our population would ensure the availability of adequate medical care for all Canadians.

Any proposal will be recommended to the Commission as to the manner in which the needs of the citizens in the field of health care can best be met. There will be various compromise proposals lying between two basic choices - first, that government resources should be devoted exclusively to areas of need only and with the great majority of citizens left free to meet their health needs in a competitive free economy without assistance or subsidy - and second, that there should be a universal compulsory plan without choice and financed in whole or in part by government revenues. The Chamber



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4 feels strongly that there can be no satisfactory compro-
5 mise between these two basic principles in the long run
6 and that any deviation from the former, however well
7 intentioned, will ultimately and certainly lead to the
8 latter in the end.

9 THE CHAIRMAN: Thank you, Mr. Hunter.
10 Have your associates anything they wish to add now or
11 any comments to make?

12 MR. KILGOUR: If I can add one point, Mr.
13 Chairman, which I think is particularly pertinent in
14 relation to the conclusion which is reached in this
15 brief, which was printed before the sessions that have
16 taken place this week: we make the point that there is
17 no compromise between the two principles of merely
18 meeting need or of government intrusion into the whole
19 field, and I think that point was very aptly illustrated
20 but not clearly illustrated when the Government of Mani-
21 toba's brief was presented here on Monday. I was here
22 at that presentation and it was perfectly clear that
23 Premier Roblin was utterly unwilling to put a price tag
24 on his proposals, that in fact he asked for a Federal
25 Government grant that could then be spent in the best
26 interests of the province, so that in his carefully
27 chosen words he made it perfectly clear he was not going
28 along with a compulsory government plan. On the other
29 hand, in his brief, there were three principles set forth,
30 and, if I could, I would like to just illustrate what
those mean in my judgment as indicating the fact that
there can be no compromise.

His three principles were reached on page



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His three principles were presented on page



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4 ll of the brief, and followed a rather glowing tribute to
5 the effectiveness of the Manitoba Medical Service, and
6 the great service they are rendering people in Manitoba
7 in giving them first-dollar coverage which everybody
8 appears to want -- some 400,000 people. Clearly, that
9 has the approbation of the Government -- the standard of
10 service being delivered by the Manitoba Medical Service.

11 Then he suggests there are three essential
12 principles that must be followed by government: (1) that
13 it is universally available; (2) that it be on a stipu-
14 lated premium within the range of the great majority of
15 the citizens of Manitoba. Now, that, I suggest, is
16 taken by the reader -- clearly by both our newspapers --
17 as meaning that the Government is going to subsidize the
18 premium down to some acceptable point, but right across
19 Canada governments have settled that \$48 is about a politi-
20 cal maximum you can charge for people in all walks of
21 life.
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11 of the price, and followed a rather glowing tribute to
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Canada governments have settled that \$2 is about a politi-
cal maximum you can charge for people in all walks of
life.



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4 That prevails in Manitoba, in the hospital plans in
5 Ontario and Saskatchewan. I think most people are
6 entitled to conclude that a supported premium costs you
7 about \$48 a year for this universal care of Manitoba
8 Medical Service. It will be voluntary so that means
9 nobody has to go in; now, if one examines this perhaps
10 in the light of the assumption that I have taken that
11 most people will conclude that an acceptable program is
12 about \$48 you find the cost of such a plan would be, I
13 think, one could conservatively assume, \$29,000,000 or
14 \$30,000,000 a year not including drugs or ancillary
15 services.

16 THE CHAIRMAN: That is for Manitoba?

17 MR. KILGOUR: Yes.

18 THE CHAIRMAN: At a population of some
19 900,000 people?

20 MR. KILGOUR: Yes, something over 900,000.
21 I think one could get agreement that plus or minus 10%
22 it is in the \$29,000,000 to \$30,000,000.

23 THE CHAIRMAN: What is the difference in
24 population between Manitoba and Saskatchewan?

25 MR. KILGOUR: They are very close, Saskat-
26 chewan is slightly larger.

27 THE CHAIRMAN: Well, the figure that has
28 been more or less accepted is between \$21,000,000 and
29 \$22,000,000 for Saskatchewan.

30 MR. KILGOUR: On the other hand, one can
get it in a sense this way; the Manitoba Medical group
is \$108 per family and if you reduce that to \$48 a family
you have \$60 of government subsidy per subscriber if they



...the ...
...the ...
...the ...

about \$28 a year for this universal care of Manitoba
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in the light of the assumption that I have taken that
most people will conclude that an acceptable program is
about \$28 you find the cost of such a program would be, I
think, one could conservatively assume, say, \$10,000 or
\$20,000,000 a year not including drugs or ancillary
services.

THE CHAIRMAN: That is for Manitoba?

MR. KING: Yes.

THE CHAIRMAN: On a population of some

200,000 people?

MR. KING: Yes, something over 200,000.

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it is in the \$20,000,000 to \$25,000,000.

THE CHAIRMAN: What is the difference in

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MR. KING: They are very close, 250,000-

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MR. KING: On the other hand, the one

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I have 500 of Government actually per subscription of that



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3 continue the same level of service on the same schedule
4 of fees.

5 THE CHAIRMAN: The assumption is that
6 medical service will cost as much as hospitalization, I
7 mean, on your \$48 business?

8 MR. KILGOUR: I am only using the existing
9 premiums and the \$48 seems to be the one that is commonly
10 chosen by government as the amount they can charge people
11 in all walks of life. If one accepts those terms as a
12 conclusion that one might be driven to, if you accept
13 this principle it comes out to a governmental cost of not
14 less than \$16,000,000 a year. What we collect in Manitoba
15 on hospital premiums which are compulsory is about
16 \$13,000,000 a year so if one holds out a \$30,000,000
17 service as available and collects \$13,000,000 there is
18 about \$16,000,000 to \$17,000,000 minimum to be raised
19 by government. That, in fact, in Manitoba, would give
20 you a little change out of a 3% sales tax. I do not
21 think any of the people who read the conclusions or the
22 character or formed a judgment of the Manitoba brief
23 was conscious that the implications of this brief were
24 a \$16,000,000 or \$17,000,000 a year bill. I suggest
25 that those flow from that.

26 The third one was that it be voluntary.
27 Now, this is not a voluntary scheme if you get a govern-
28 ment subsidy running to the order of \$60 a family or
29 with the Government paying two-thirds of the cost of the
30 bill. In fact, it is just as compulsory as your hospitali-
zation when the Federal Government said they would pay
half the cost of hospitalization for those provinces that

of fees.

THE CHAIRMAN: The assumption is that medical service will cost as much as hospitalization, I mean, on your \$48 business?

MR. KILGOUR: I am only using the existing premiums and the \$48 seems to be the one that is commonly chosen by government as the amount they can charge people in all walks of life. If one accepts those terms as a conclusion that one might be driven to, if you accept this principle it comes out to a governmental cost of not less than \$16,000,000 a year. What we collect in Manitoba

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The third one was that if the government, now, this is not a voluntary scheme if you get a government subsidy running to the order of \$80 a family or with the government paying two-thirds of the cost of the bill. In fact, it is just as compulsory as your hospital



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3 adopt the universal plan, any province that chose to stay
4 out was in effect having its citizens taxed to pay for
5 the provinces that went in. The implications of that
6 were clearly recognized and once they started to break
7 everyone came in and finally even Quebec came in. In
8 effect if we subsidize the majority of people in Manitoba
9 by a government subsidy and premium then those people who
10 do not want to go in are being taxed for those who are
11 and it is, therefore, virtually compulsory for anyone who
12 understands the facts of life to go into a plan once
13 there is such an important element of government subsidy.
14 I make that point believing it to be correct. To illus-
15 trate that, no matter how well intended a government plan
16 that tries to support premiums, everybody is in fact
17 adopting a plan that is virtually the same as the Saskat-
18 chewan concept even though it is two or three years
19 removed from its original conception.

20 I might mention two points, that is the
21 true importation of what the public will read into the
22 Government's proposal, not what the Premier said but
23 what one can read into it if you follow it through.
24 Second is that the Manitoba Medical Service brief, the
25 Medical Association plan that the Government should
26 confine its operation only to need and there there was a
27 cost of \$5,000,000 to \$6,000,000 and perhaps that could
28 be reduced by a more studied approach that comes very
29 much closer, I suggest, to meeting the Chamber's view
30 that government's dollar should be given to those areas
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removed from its original conception.
17 chevan concept even though it is two or three years
16 adopting a plan that is virtually the same as the basket-
15 that tries to support premiums, everybody is in fact
14 trate that, no matter how well intended a government plan
13 I make that point believing it to be correct. To illus-
12 there is such an important element of government subsidy,
11 understands the facts of life to go into a plan once
10 and it is, therefore, virtually compulsory for anyone who
do not want to go in are being taxed for those who are
by a government subsidy and premium then those people who
effect it we subsidize the majority of people in Manitoba
everyone came in and finally even Quebec came in. In
were clearly recognized and once they started to break
the provinces that went in. The implications of that
out was in effect having its citizens taxed to pay for



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3 compulsory government scheme perhaps one stage removed.

4 THE CHAIRMAN: Thank you very much, Mr.
5 Kilgour. Are there any further comments? Perhaps just
6 as a matter of general information, on page 2 under item
7 1(c) you say whether there are or not other than rare
8 instances of true hardship, the figure we have been given
9 was that there would be approximately 40,000 to 45,000
10 people in Manitoba who will never pay any premiums at
11 all. Those are the ones who are now in the social assis-
12 tance category. Is that the group you say would search
13 out for the rare instances?

14 MR. HUNTER: I think what we had in mind
15 there was that the group that are indigents and so on
16 do come under the Medicare Plan but there may be others.

17 THE CHAIRMAN: This is additional?

18 MR. HUNTER: Those are others that would
19 have a calamity sickness or illness.

20 MR. KILGOUR: I think it is true while
21 the terms of reference of this Commission are only
22 medical care, you must recognize the terms of the biggest
23 hardship is frequently loss of wages and not the inability
24 to receive medical care. This is an area of hardship
25 that has a far greater impact on Canadian families and
26 causes far greater distress than any inability to pay
27 doctors' bills.

28 THE CHAIRMAN: In fact it is a postponement
29 of payment?

30 MR. KILGOUR: If a man loses wages for
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4 THE CHAIRMAN: When he gets back to work
5 he still has to pay the doctor.

6 MR. KILGOUR: In the meantime he has to
7 eat so the greatest distress is loss of income, not
8 medical bills.

9 THE CHAIRMAN: On page 7, line 5 you say:
10 "It has been estimated that the cost of
11 adding a national medical care plan to
12 existing government spending in the health
13 field, would raise the total of such
14 spending by all governments by 33% or to
15 over 1.1/2 billion dollars ---"

16 Are you in a position to give us the
17 source of that computation?

18 MR. HUNTER: Yes, that was from the
19 Financial Post of November 11 1961 and the figures that
20 were used there, such a scheme would raise the total
21 spending on health by 33% or a grand total of \$1,600,000,000
22 per year for a starter. That was the source of the figure.
23 The figures used for or relating that to personal income
24 tax and corporation taxes were taken from the budget
25 papers of June 20 and the figures there were \$1,711,000,000
26 for income tax and \$1,276,000,000 for corporate taxes and
27 we related it to those two.

28 COMMISSIONER McCUTCHEON: What kind of
29 premium did the Financial Post assume would be charged?
30 I take it this is the net government expenditure but did
31 they make any assumption on that? They must have.

32 MR. KILGOUR: I think not. Mr. Douglas'
33 estimate was one billion dollars a year for medical care.



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3 COMMISSIONER McCUTCHEON: Alone?

4 MR. KILGOUR: Yes, and the record of
5 estimates in this field has been - usually it is 50% to
6 100% under-estimated and I think that is true of most
7 government hospital estimates.

8 COMMISSIONER McCUTCHEON: That was true of
9 the hospital experience in Ontario.

10 MR. KILGOUR: And the British scheme,
11 there were some errors in estimating cost.

12 COMMISSIONER McCUTCHEON: How do you
13 answer the question that has been raised in some quarters
14 that insofar as employee groups are concerned there is
15 in most of them a considerable subsidy by reason of the
16 employer's share being allowed for income tax purposes
17 whereas the self-employed has no such right.

18 MR. HUNTER: Well, that is really part of
19 the wage. I take it what you are referring to is the
20 built-in labour agreement that the Government will pay
21 50% of the Manitoba Medical Service and 50% of the
22 hospital plan. These are fringe benefits, they are
23 built in as part of the wage structure and in the case
24 of a self-employed man, he has to figure that as part of
25 his own expenses.

26 COMMISSIONER McCUTCHEON: I would like to
27 press that a little further and I would like an answer to
28 it. The 50% that the employer pays never forms part of
29 the wage, never becomes subject to personal income tax.
30 On the other hand, the 50% that the employee pays never
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3 members of employer groups are receiving a subsidy from
4 the Federal Government.

5 MR. KILGOUR: I think that is probably
6 correct but it is a rather minor one. It might just as
7 easily be in wages and it would be the same thing, it
8 would be taxable to the individual.

9 THE CHAIRMAN: But it is not taxable to
10 the individual now?

11 MR. KILGOUR: Granted there are many
12 inequalities between the salaried workers and self-
13 employed people that the tax laws have never been able to
14 resolve. Of course, contributions to a welfare plan is
a few dollars a month.

15 THE CHAIRMAN: Have you got the analysis
16 that was made by the Mercer firm of what the cost would
17 be of a national medical care plan?

18 MR. HUNTER: Apparently not.

19 COMMISSIONER FIRESTONE: Mr. Hunter, I
20 believe your brief emphasizes that in developing plans
21 for extended health services and particularly medical
22 care, the Commission should bear in mind two principles,
23 if I may restate the principles. As I understand them,
24 one, that such plans do not adversely affect the producti-
25 vity of our nation and two, that any plans that are
26 developed do not interfere with the effective working
of Canada's basic productivity enterprise system. Do I
understand those two principles correctly?

27 MR. HUNTER: That is correct and I think
28 the other, that is, that any effort should be in areas
29 of need.
30

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MR. HUNTER: That is correct and I think



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4 COMMISSIONER FIRESTONE: Now, I might say
5 I understand why you put forward these principles because
6 the history of Canadian development has shown that by
7 following these two principles we have been able to
8 achieve a comparatively high standard of living, high
9 return on income etc. so these two perhaps have support
10 in the history of the Canadian economy. Would you agree
11 that the attainment of a high standard of health should
12 be one of the objectives of national policy in Canada?

13 MR. HUNTER: I think the availability
14 should be an objective and educating the people to the
15 importance of health.

16 COMMISSIONER FIRESTONE: This would be all
17 part and parcel of an effort to attain a high standard
18 of health?

19 MR. HUNTER: Yes.

20 COMMISSIONER FIRESTONE: Would you agree
21 that improvement of health of the Canadian nation can
22 contribute to an improvement in productivity and increase
23 the national output of the Canadian economy?

24 MR. HUNTER: I think in principle that it
25 certainly has been suggested that it varies. Personally
26 I am not so sure it necessarily follows. I do not think
27 that merely having good health is going to increase the
28 productivity, I think it is having the initiative, the
29 enterprise, that is going to increase productivity and
30 not necessarily just good health.

COMMISSIONER FIRESTONE: Would you not
feel that a worker who is in good health and loses fewer
hours of work because of sickness that it is better for



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the operation of a plant and would contribute to the
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MR. HUNTER: I think so.

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4 COMMISSIONER McCUTCHEON: Good health in
5 that area of the population which is engaged in productive
6 work?

7 MR. HUNTER: Yes.

8 COMMISSIONER FIRESTONE: Mr. Hunter, if a
9 person is sick in bed he does not produce. Now, if, say,
10 the average working person in Canada loses, say, five
11 working days a year because of illness, he would not
12 produce anything during that time. Now, if as a result
13 of improved and comprehensive health services the average
14 time lost because of illness could be reduced to, say,
15 three days, would you say that as a result of this the
16 nation as a whole would produce more?

17 MR. HUNTER: No, I wouldn't want to go
18 that far. I would say in theory yes, but again it is --
19 going along with you, you may have shorter work weeks,
20 and so on, so that you will not necessarily produce more,
21 because you keep them out of bed for two days less than
22 otherwise would be.

23 COMMISSIONER FIRESTONE: Well sir, we are
24 not talking about what might happen. I am just putting
25 a very simple question to you, Mr. Hunter. If people, on
26 an average, lose five days per week work, and under our
27 present system, and assuming that there are opportunities
28 for them to work, obviously if there are no jobs there
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5 working obviously, we are worried about them being off
6 work. Today those people do not have adequate medical
7 care and by giving them adequate medical care this is
8 going to keep them out of the sick bed. It seems to me
9 that if by working and earning a wage, and there are
10 adequate medical services available, they should pay for
11 them. The people you refer to are people employed and
12 should pay the medical bills.

13 COMMISSIONER FIRESTONE: I am not at this
14 point asking who is paying medical bills. I am just
15 trying to establish the economic impact of people being
16 healthy or people being sick. You have talked in your
17 brief about the impact on the Canadian economy of a
18 health program. I would like to establish what this
19 really means in economic terms.

20 MR. KILGOUR: We are all aware I think
21 that one group in Canada that is insured, and that I
22 am told has the highest absenteeism from illness of any
23 group in Canada, and that is the Federal Civil Service.
24 I am reliably told they have the greatest number of days
25 away.

26 THE CHAIRMAN: Does that include the
27 judges too, Mr. Kilgour?

28 MR. KILGOUR: ---but they are all well
29 cared for. They are living in cities in which there is
30 excellent health care, and I suggest that perhaps the
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4 COMMISSIONER FIRESTONE: Just to pursue
5 the question a little further, would you say that if
6 people on an average lose three days of work instead
7 of five days of work, they would produce more?

8 MR. KILGOUR: If they lose three days of
9 work a year?

10 COMMISSIONER FIRESTONE: A year instead
11 of five days of work, they would produce more.

12 MR. KILGOUR: I would hope so.

13 COMMISSIONER FIRESTONE: Well, if you
14 would hope so, and I assume this is the case, as your
15 economist would tell you if you want to consult him, the
16 question then arises whether improved health services,
17 in achieving a reduction in the number of days lost
18 because of illness, would not mean an increased output
19 in the nation, and with it higher incomes, higher expendi-
20 tures, higher sales, higher profits, and a higher standard
21 of living. If we have an increased output some of the
22 consequences of that are the points I have mentioned,
23 higher income, higher expenditures, higher sales, higher
24 profits, if you operate efficiently, and a higher stan-
25 dard of living.

26 MR. KILGOUR: If it could be operated
27 without changing some of the other elements in the mosaic
28 of living, it would be. There are many factors affecting
29 absenteeism and productivity, rather than the number of
30 days ill a year.

COMMISSIONER FIRESTONE: I accept the
qualification, and if we might proceed on that basis.
Would you agree therefore, and I will turn to Mr. Hunter



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3 if I may, that there is an important link between the
4 state of good health of the nation and the nation's
5 ability to increase its national output, employment, and
6 income?

7 THE CHAIRMAN: I don't want to interfere
8 with your questioning, but I don't think that questions
9 need necessarily be put, or answered, by any individual.
10 The group may collectively or individually answer.

11 COMMISSIONER FIRESTONE: Yes, I am
12 addressing it to you, Mr. Hunter and please feel free to
13 ask any of your associates to answer in any way you wish.
14 Would you agree, in the light of the discussion that we
15 have had so far and the answers that you have given to
16 the questions, that there is an important link between
17 the state of good health of the nation and the nation's
18 ability to increase its national output, employment, and
19 income?

20 MR. HUNTER: Yes, I think that is a correct
21 statement of theory.

22 COMMISSIONER FIRESTONE: Thank you. I
23 assume it is not only correct in theory, that we are
24 aiming to apply this theory also in practice to achieve
25 this objective?

26 MR. HUNTER: Yes.

27 COMMISSIONER FIRESTONE: Thank you. I
28 take it the Chamber of Commerce of Manitoba is in favour
29 of a high level of employment and income in Canada?

30 MR. HUNTER: Definitely.

COMMISSIONER FIRESTONE: Are you aware
that the trend of economy has been in the direction of a

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3 proportionately greater increase in employment in the
4 service industries than in the commodity-producing
5 industries?

6 MR. J.S. McMAHON: Yes.

7 COMMISSIONER FIRESTONE: Are you familiar
8 with the fact that there are now more than 50% of our
9 population working in the service sector in Canada, and
10 that a somewhat similar situation exists in the United
11 States and many other industrialized countries?

12 MR. HUNTER: I believe that is so.

13 MR. McCUTCHEON: You said 50% of the popula-
14 tion, you mean ---

15 COMMISSIONER FIRESTONE: 50% of the working
16 population?

17 MR. HUNTER: Yes.

18 COMMISSIONER FIRESTONE: Assuming this was
19 so, and you can verify the figure after the meeting,
20 would you agree that health services are an important
21 part of the service sector of the Canadian economy?

22 MR. KILGOUR: Numerically they are quite
23 small, but they are a most important part, yes.

24 COMMISSIONER FIRESTONE: Would you feel
25 that an improvement in health services would lead to an
26 expansion of the health sectors of the Canadian economy,
27 and this would mean not only improved health to those
28 receiving the service, but also mean increased opportuni-
29 ties to find employment and earn incomes to those that
30 provide health services?

MR. KILGOUR: I think undoubtedly it would
result in increased employment. I don't think there is



COMMISSIONER FIRESTONE: Are you familiar

with the fact that there are now more than 50% of our
population working in the service sector in Canada, and
that a somewhat similar situation exists in the United
States and many other industrialized countries?

MR. KILGOUR: I believe that is so.

MR. MCCUTCHEN: You said 50% of the popula-

tion, you mean ---

COMMISSIONER FIRESTONE: 50% of the working

COMMISSIONER FIRESTONE: Assuming this was

so, and you can verify the figure given the meeting,
would you agree that health services are an important
part of the service sector of the Canadian economy?

MR. KILGOUR: Numerically they are quite

small, but they are a most important part, yes.

COMMISSIONER FIRESTONE: Would you feel

that an improvement in health services would lead to an
expansion of the health sector of the Canadian economy,
and this would mean not only improved health to those
receiving the service, but also mean increased opportuni-
ties to find employment and earn incomes to those that

MR. KILGOUR: I think undoubtedly it would

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4 any question that the Government intrusion into a medical
5 plan would have more people involved in it to administer
6 it than would be possible under any other mechanism, but
7 on the other hand when you speak of improvement in the
8 health facilities, I would like, if I may, to quote a
9 pertinent statement from the British Medical Journal of
10 Saturday, December 9th, 1961, in which Lord Taylor,
11 opening a debate in the House of Lords on the growing
12 shortage of doctors described, in a place not encouraging
13 exaggeration, the present position as "a pretty ghastly,
14 awful picture", and as "a new and desperate situation".
15 He then went on to say the number of foreign doctors who
16 had come to Britain, and he found, for example, such a
17 state of affairs in mental hospitals as to conclude "It
18 is very rare indeed that you will find the staff of a
19 mental hospital now is an English or a British staff".
20 There also appears to be a shortage of casualty officers.
21 Referring to the non-teaching hospitals - by far the
22 largest number in the N.H.S. - he said "I cannot recommend
23 your Lordships to go into such hospitals as a casualty,
24 for there is in many cases no casualty officer.. A house
25 surgeon will have to leave the theatre when he can, to
26 treat you, and his experience will be far less than that
27 of your own general practitioner. When he comes he will
28 probably not be a British graduate and he could well
29 have difficulty in understanding what you say. This is
30 at a time when speed and efficiency may be literally life-
saving".

28 So I am not convinced that the mere numeri-
29 cal additions to the people in health care produce a
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3 situation which is conducive to better health care.

4 THE CHAIRMAN: I suppose you have Lord
5 Beveridge's statement of the same day?

6 MR. KILGOUR: No, Lord Beveridge has been
7 up and down ---

8 THE CHAIRMAN: But it is on the same
9 lines?

10 MR. KILGOUR: Yes, certainly.

11 COMMISSIONER FIRESTONE: Would you say
12 that extended health services will lead to increased
13 opportunities to provide employment and to earn income?

14 MR. KILGOUR: Sir, I think more people
15 employed in the service field, yes, I think the number
16 of bodies in it might well increase.

17 COMMISSIONER FIRESTONE: And also the
18 number of opportunities to earn income in this sector
19 would increase, the health service sector, as you provide
20 more services, or as the nation requires more services?

21 MR. KILGOUR: I am caught a bit on the
22 question.

23 COMMISSIONER FIRESTONE: I will restate
24 the question to be of help to you. We are talking of
25 the nation's demanding greater health services, and if
26 such health services are provided it will mean more jobs
27 for more people, and there will be more income for the
28 people who provide those services. Do you agree with
29 that, and if we are going to expand the health sector,
30 we might as well expand it in the sector that will do
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3 have reservations in this sense, that healthful growth
4 is what we want. If we can have more able practising
5 physicians, to me that will contribute to the health.
6 If we have a frustrated group, plus a lot of clerks, I
7 don't think that will add to the health of the people of
8 Canada.

9 COMMISSIONER FIRESTONE: Would you not
10 feel that since the Canadian economy seems to be expanding
11 perhaps more rapidly in the service sector than in the
12 commodity sector, that whatever expansion does take
13 place in the service sector, we should endeavour to
14 expand that part of the service sector which will yield
to the Canadian economy the greatest dividends?

15 MR. KILGOUR: Yes, and under the free
16 enterprise system those areas will expand more rapidly.

17 COMMISSIONER FIRESTONE: We are not
18 discussing the free enterprise area at this point. We
19 are just dealing with the principle as we go along, so
20 your answer to my question was yes, and I take it that
21 if we are in agreement that health has important economic
22 implications, as we have developed as we have gone along,
23 it is desirable to increase, if we can, the health
24 service sector within the service sector, provided this
25 can be done efficiently and it has beneficial effects
on the Canadian economy?

26 MR. KILGOUR: I think that is a generaliza-
27 tion, but one I would probably subscribe to.

28 COMMISSIONER FIRESTONE: Thank you. In
29 order to provide extended health services in the Canadian
30 economy, we have to spend more money on such health



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4 MR. KILGOUR: Yes, I think so.

5 COMMISSIONER FIRESTONE: Can we discuss
6 therefore for a moment where the money is going to come
7 from to pay for such extended health services? Would
8 you feel that comprehensive medical care facilities
9 should be available to all Canadians on a practical and
10 realistic basis, using the most efficient manner possible
11 to obtain such services?

12 MR. KILGOUR: Yes sir.

13 COMMISSIONER FIRESTONE: If we had in
14 Canada a comprehensive, prepaid medical plan, or plans,
15 would you feel that this would assist in achieving this
16 objective?

17 MR. KILGOUR: Yes I think I do.

18 COMMISSIONER FIRESTONE: Would you agree
19 that those that could pay premiums to support such a
20 plan should pay them?

21 MR. KILGOUR: Quite so.

22 COMMISSIONER McCUTCHEON: If they wish to
23 pay.

24 MR. KILGOUR: If they wish to pay. You
25 said available ---

26 COMMISSIONER FIRESTONE: That is correct.

27 MR. KILGOUR: In fact, I think there should
28 be many more than one plan. There should be a wide range
29 of plans.

30 COMMISSIONER FIRESTONE: As I said in my
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3 COMMISSIONER FIRESTONE: Would you agree
4 that those who couldn't pay those premiums in full or
5 in part, the State should pay for the difference?

6 MR. KILGOUR: There one comes to some --
7 we come into a very grey area as to where you say those
8 people who cannot pay the premiums. We can all agree
9 that those who are without resources we should. When it
10 comes into the grey area of where one has the capacity to
11 pay the premium or not, I don't know.

12 COMMISSIONER FIRESTONE: I was trying to
13 make the question helpful and easy for you, by saying
14 those who can either not pay or can only pay in part.
15 We are not getting involved in any quantitative assessment
16 who or how many. We are just concerned with the principle.

17 MR. KILGOUR: I think that is entirely
18 consistent with the ---

19 COMMISSIONER FIRESTONE: Would you there-
20 fore also say that those who cannot pay their premiums in
21 full or in part, the State might be called upon to pay
22 the difference?

23 MR. KILGOUR: Yes.

24 COMMISSIONER FIRESTONE: Thank you. Now,
25 how should the State pay for this difference?

26 MR. KILGOUR: Clearly from taxation, and
27 clearly through setting up some service to see that it
28 worked.

29 COMMISSIONER FIRESTONE: Fine sir. In
30 paragraph 5 on page 7 of your submission you say:

"If new structural costs are incurred or
imposed by government, such costs would



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3 have to be financed by increased taxation
4 or by deficit borrowing".

5 Is this necessarily the case, sir, that
6 we must increase taxes for the Government to spend more
7 on health services? You say here:

8 "It has to be financed by increased
9 taxation or by deficit borrowing".

10 MR. KILGOUR: Yes, I think one can say
11 categorically to the extent that you are going to provide,
12 or pay for, services that are not now existing, that the
13 Government has to raise the money by added taxation.

14 COMMISSIONER FIRESTONE: By added taxation
15 do you mean, sir, an increase in the taxation rates, or
16 increased tax take?

17 MR. KILGOUR: Well, certainly they have
18 got to raise more money for the additional expenditure.

19 COMMISSIONER FIRESTONE: Without neces-
20 sarily increasing the tax rate though?

21 MR. KILGOUR: Not necessarily.

22 COMMISSIONER FIRESTONE: May I help you
23 sir? If the Canadian economy, the gross national product
24 of Canada, expands by 5%, and the same taxation rate
25 levels are retained, would this not increase the revenue of
26 the Government?

27 MR. KILGOUR: Undoubtedly sir.
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4 COMMISSIONER FIRESTONE: Would the implica-
5 tion not be that as the Canadian economy expands we can
6 afford to spend more on health services in absolute
7 terms without increasing the burden or the ratio of
8 structural cost to the total economy?

9 MR. KILGOUR: I follow your line of econo-
10 mic reasoning, I think, sir, but it can get seriously
11 sort of off the beam if one looks at a practical illustra-
12 tion. To come back for a moment to my earlier suggestion,
13 if the Manitoba Government would try to put up \$16,000,000
14 a year they would clearly have to put on new taxation,
15 and conceivably in ten years we may get it back in produc-
16 tivity, but it would be a long time. It wouldn't happen
17 within a two or three or five-year period. I use large
18 figures to illustrate that what may be true in a genera-
19 tion on a theoretical approach is not necessarily effec-
20 tive in a practical way -- certainly not within a short
21 time.

22 COMMISSIONER FIRESTONE: But since we are
23 talking here about a basic principle, would you agree
24 that as our economy expands we can afford more to spend
25 on health without increasing the ratio of our structural
26 cost to total economic productivity?

27 MR. KILGOUR: So far it is going the other
28 way: we are always spending a larger percentage. I would
29 like to see your theory result some day, but so far we
30 have always continued to spend an increasing share without
31 this productivity ever being permitted to get ahead of it.

32 COMMISSIONER FIRESTONE: We are looking to
33 the future, and wouldn't you feel that as the Canadian

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6 MR. KILGOUR: Oh, and the public will.

7 COMMISSIONER FIRESTONE: Therefore, the
8 answer to my question is that the Canadian economy can
9 afford to spend more on health services as our economy
10 grows?

11 MR. KILGOUR: Yes, sir.

12 COMMISSIONER FIRESTONE: Without neces-
13 sarily increasing the ratio of what you call structural
14 cost to total economic productivity, because you seem to
15 be worried about this point,

16 MR. KILGOUR: Yes, sir.

17 COMMISSIONER FIRESTONE: I understand from
18 your submission that you are in favour of retaining the
19 basic private enterprise system of the Canadian economy:
20 does this mean as far as health services are concerned
21 that you feel that those that can look after their own
22 health services should do so?

23 MR. KILGOUR: Yes, sir.

24 COMMISSIONER FIRESTONE: And did I under-
25 stand you to say a little earlier you have no objection
26 to the State paying for health services of those who
27 cannot afford to pay?

28 MR. KILGOUR: Again, with a shading of
29 definition, but certainly of those who are unable to pay,
30 clearly, we are in favour of that.

31 COMMISSIONER FIRESTONE: Would you say
32 that the one effective way of assuring the continuation
33 of an efficient private enterprise system in Canada would



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4 prise and government?

5 MR. KILGOUR: Yes, sir.

6 COMMISSIONER FIRESTONE: Would you say if
7 a national medical care plan were developed that such
8 co-operation should extend to business participating in
9 the development of a program that is acceptable to the
10 majority of Canadians?

11 MR. KILGOUR: That question was a little
12 over-simplified for my capacity to answer it.

13 COMMISSIONER FIRESTONE: How would you
14 like to deal with this question?

15 THE CHAIRMAN: I don't know what you mean,
16 Dr. Firestone. I think you must rephrase the question.

17 COMMISSIONER FIRESTONE: Well, Mr. Kilgour,
18 we are speaking of increased co-operation between business
19 and government, and I would like to translate that
20 increased co-operation into a practical form. I take it
21 that business can co-operate by expressing its views and
22 participating in the development of a program or a plan
23 that is acceptable to the majority of Canadians, and that
24 it is also the policy principles which business like you,
25 as the Chamber of Commerce, have set forth?

26 MR. MORRISON: If I may add something here,
27 Mr. Chairman, I think that introduces a new element that
28 has not been present in the past, and that is the right
29 of the public to have an opportunity to express their
30 view on this question. I think that is very important.
I think the public interest will settle this in the end
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4 COMMISSIONER FIRESTONE: I take it the
5 answer is that increased co-operation means that business
6 participates in the development of such a plan and
7 expresses its views particularly if a form is developed
8 in which this can be done?

9 MR. KILGOUR: Yes, and in fact today I
10 would say that business has, and the medical profession
11 and your medical service plans do offer the public of
12 Canada today a choice of health plans that is as wide as
13 any available in the world. This does not necessarily
14 mean subscribing to a government plan. In fact, it is
15 the very flexibility and depth of variety of coverage
16 that gives the public this choice.

17 COMMISSIONER FIRESTONE: I am referring
18 to an advisory capacity: business can contribute through
19 advice in the developing of a sound plan for Canada.

20 MR. KILGOUR: I would agree most heartily.

21 COMMISSIONER FIRESTONE: That leads me to
22 my final question: if there was set up in Canada a
23 National Health Council or Provincial Medical Care Boards,
24 representing, say, representatives from business, finance,
25 the professions, labour and farm groups, would you be in
26 favour of such a Board which would advise government or
27 governments on the development of a realistic and sound
28 health program for Canada?

29 MR. KILGOUR: Do you mean to advise them
30 on the adoption of one plan? To me, one of the great
strengths is the variety of plans in Canada. Canada is
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3 you are talking of advising on one plan ---?

4 COMMISSIONER FIRESTONE: On a plan or
5 plans?

6 MR. KILGOUR: On the area of health care,
7 yes, but not necessarily on a particular plan.

8 COMMISSIONER FIRESTONE: On a plan or
9 plans, which would involve several plans, as you have
10 suggested.

11 MR. KILGOUR: I think it is always helpful
12 to have business and government exchange views on matters
13 of importance.

14 COMMISSIONER FIRESTONE: And your Winnipeg
15 Chamber of Commerce would support the setting up of such
16 a National Health Council or Provincial Medical Care Board
17 which would perform, say, an advisory function?

18 MR. KILGOUR: Is this just an advisory
19 committee on a general problem, or a committee to help
20 government set up a compulsory plan?

21 COMMISSIONER FIRESTONE: At this stage we
22 are concerned with the advice and the participation of
23 business in developing some sound plan for Canada and a
24 sound plan for Manitoba.

25 MR. HUNTER: I think we have taken the
26 position in our brief that we feel we have good facilities
27 now for most of the people in Manitoba. There are
28 certain areas not covered. We feel the objective of
29 government should be to cover those areas, and we are
30 not suggesting -- certainly, we are not suggesting there
be a universal plan, and therefore, if in the areas where
there is no coverage now government said, "Will business

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COMMISSIONER FIRESTONE: On a plan or

MR. KINGOUR: On the area of health care,

yes, but not necessarily on a particular plan.

COMMISSIONER FIRESTONE: On a plan or

plans, which would involve several plans, as you have suggested.

MR. KINGOUR: I think it is always helpful

to have business and government exchange views on matters of importance.

COMMISSIONER FIRESTONE: And your Winnipeg

Chamber of Commerce would support the setting up of such a National Health Council or Provincial Medical Care Board which would perform, say, an advisory function?

MR. KINGOUR: Is that an advisory

committee on a general problem, or a committee to help government set up a compulsory plan?

COMMISSIONER FIRESTONE: At this stage we

are concerned with the advice and the participation of business in developing some sound plan for Canada and a sound plan for Manitoba.

MR. HUNTER: I think we have taken the

position in our brief that we feel we have good facilities now for most of the people in Manitoba. There are

certain areas not covered. We feel the objective of

government should be to cover those areas, and we are

not suggesting -- certainly, we are not suggesting there

be a universal plan, and therefore, if in the areas where

there is no coverage now government said, "Will business



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3 co-operate?", yes, of course they would.

4 COMMISSIONER FIRESTONE: You realize, sir,
5 by just making one single submission and expressing your
6 view a problem is not resolved? It takes time to develop
7 a plan, and presumably if such a sound plan is to be
8 developed over a long period of time, as Mr. Kilgour has
9 suggested -- you don't do things overnight -- in developing
10 such a plan government should have the best help it can
11 get in Canada: it includes the medical profession, busi-
12 ness, finance, labour, farmers, etc. It therefore needs
13 a forum where this advice is continuously given and there
14 is an exchange of views. Otherwise, you have to wait
15 many years to have a Royal Commission appointed. I am
16 thinking of things that may happen after this Royal
17 Commission disappears. You want a continual exchange of
18 views. Would you feel as responsible citizens and as
19 representatives of business and finance you could offer
20 this advice within a forum of a provincial advisory
21 body and a national advisory body if such a body were to
22 be set up?

23 MR. HUNTER: Yes, we would, as long as it
24 is understood that in favouring such a body, whether at
25 a provincial or national level, as long as it was dealing
26 with the area of need and not imposing a compulsory univer-
27 sal plan, because that destroys the whole thing as far as
28 our submission and the belief we have is concerned. We
29 say, if in the area not being covered now, in the areas
30 of need, the Government is anxious to try and work out a
plan to cover these areas, certainly we, as businessmen,
would be happy to co-operate and advise.

COMMISSIONER TIRRELL: You realize, sir,
by just making one single submission and expressing your
view a problem is not resolved? It takes time to develop
a plan, and presumably if such a sound plan is to be
developed over a long period of time, as Mr. Kilgour has
suggested -- you don't do things overnight -- in developing
such a plan government should have the best help it can
get in Canada: it includes the medical profession, busi-
ness, finance, labour, farmers, etc. It therefore needs
a forum where this advice is continuously given and there
is an exchange of views. Otherwise, you have to wait
many years to have a Royal Commission appointed. I am
thinking of things that may happen after this Royal
Commission disappears. You want a continual exchange of
views. Would you feel as responsible citizens and as
representatives of business and finance you could offer
this advice within a form of a provincial advisory
body and a national advisory body if such a body were to
be set up?
MR. TIRRELL: Yes, we would, as long as it
is understood that in favouring such a body, whether at
a provincial or national level, as long as it was dealing
with the area of need and not imposing a compulsory univer-
sal plan, because that destroys the whole thing as far as
our submission and the belief we have is concerned. We
say, if in the area not being covered now, in the areas
of need, the government is anxious to try and work out a
plan to cover these areas, certainly we, as businessmen,
would be happy to co-operate and advise.



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4 COMMISSIONER FIRESTONE: My question was
5 not the specific details or conditions which a Board,
6 if set up, would discuss. All I am asking is a question
7 of principle, whether you feel that such a Board would
8 be a useful instrument to give the medical profession,
9 business, finance, labour and agriculture a continuing say
10 in the development of a health program for Canada? It is
11 a specific question.

12 MR. KILGOUR: When you said "program" I
13 am with you 100%, but when you said "plan" I was dubious.
14 The profession should be clearly willing to join whole-
15 heartedly with government in an examination of health
16 problems, and conceivably a health program, but not neces-
17 sarily in the development of a health plan. When one
18 thinks of a comprehensive plan or a government plan,
19 then I am afraid that carries with it a socialistic conno-
20 tation, a compulsion, that is contrary to the principles
21 that the Chamber has expressed and, I think, that most of
22 us hold individually.

23 COMMISSIONER FIRESTONE: We do not wish to
24 engage in a discussion of semantics, and we are quite
25 happy to accept your assurance that if the Government
26 were to come to the Winnipeg Chamber of Commerce -- the
27 Provincial Government if it wishes to set up a Board --
28 and required some advice from business and finance that
29 you would be happy to join such a Board to advise the
30 Government as to the health problems and how solutions
can be found acceptable to you and the majority of the
people of Manitoba.

MR. KILGOUR: Without any reservation.



not the specific details or conditions which a board, if set up, would discuss. All I am asking is a question of principle, whether you feel that such a board would be a useful instrument to give the medical profession, business, finance, labour and agriculture a continuing say in the development of a health program for Canada? It is a specific question.

MR. KILGOUR: When you said "program" I am with you 100%, but when you said "plan" I was dubious. The profession should be clearly willing to join whomever they wish to in an examination of health problems, and conceivably a health program, but not necessarily in the development of a health plan. When one thinks of a comprehensive plan or a government plan, then I am afraid that comes with it a socialistic connotation, a compulsion, that is contrary to the principles that the Chamber has expressed and, I think, that most of us hold individually.

COMMISSIONER TROTTER: We do not wish to engage in a discussion of semantics, and we are quite happy to accept your assurance that if the Government were to come to the Winnipeg Chamber of Commerce -- the Provincial Government if it wishes to set up a board -- and request some advice from business and finance that you would be happy to join such a board to advise the Government as to the health problems and how solutions can be found acceptable to you and the majority of the people of Manitoba.

MR. KILGOUR: Without any reservation.



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4 COMMISSIONER McCUTCHEON: Could I suggest
5 to you, before a person in your position would join such
6 a Board you would want to see the terms of reference
7 very clearly spelled out?

8 MR. KILGOUR: Exactly.

9 COMMISSIONER FIRESTONE: Well, let us be
10 fair: nobody wants to sign a blank cheque.

11 THE CHAIRMAN: Mr. Hunter and Mr. Kilgour
12 and Mr. Morrison, we had the Manitoba Medical Association
13 bring forward what they submitted as a plan to help to
14 look after those who are not completely indigent, but in
15 that grey class that you mentioned a while ago -- to
16 help them pay their premiums: were you here when that
17 plan was put forward?

18 MR. KILGOUR: Yes.

19 THE CHAIRMAN: And they gave a figure of
20 approximately \$5,000,000, in round figures, as the cost
21 of their program: is that a realistic figure to you
22 gentlemen?

23 MR. MORRISON: I am sorry I did not have
24 the opportunity of participating in the presentation of
25 the brief, or that figure. I think we can accept it,
26 though, as within range of the probable cost of such a
27 proposal. As I understand it, that was to assist those
28 who are not in the Medicare Plan -- some 23,000 today --
29 but rather those who are not in an income tax paying
30 position.

THE CHAIRMAN: Yes.

MR. MORRISON: And I think in relation to
these figures we have suggested today an overall cost of

COMMISSIONER: I suggest

to you, before a person in your position would join such a Board you would want to see the terms of reference

very clearly spelled out.

MR. KILGORE: Exactly.

COMMISSIONER: Well, let us be

fair; nobody wants to sign a blank cheque.

THE CHAIRMAN: Mr. Hunter and Mr. Kilgore

and Mr. Morrison, we had the Hamilton Medical Association

bring forward what they submitted as a plan to help to

look after those who are not completely indigent, but in

that class that you mentioned a while ago -- to

help them pay their expenses here you have when that

plan was put forward?

MR. KILGORE: Yes.

THE CHAIRMAN: And they have a figure of

approximately \$5,000,000, in round figures, as the cost

of their program; is that a realistic figure to you

gentlemen?

MR. MORRISON: I am sorry I did not have

the opportunity of participating in the presentation of

the brief, or that figure. I think we can accept it,

though, as within range of the probable cost of such a

proposal. As I understand it, that was to assist those

who are not in the Medicare plan -- some \$5,000 today --

but rather those who are not in an income tax saving

position.

MR. KILGORE: And I think in relation to



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4 \$30,000,000. I believe they said it would represent
5 about 25% of the population who would receive some form
6 of assistance, and that seems reasonable in relation to
7 Medicare costs plus this \$5.7 million or \$7,000,000.
8 That is about 25% of the estimate of \$28,000,000 or
9 \$29,000,000.

10 MR. KILGOUR: I would suspect that that
11 figure is probably considerably higher than a detailed
12 examination would confirm, because one can only get a
13 figure such as they did by getting some negative figures.
14 You say that there are so many taxpayers, and conversely
15 that other people are not taxpayers, and you try to fill
16 up the population in that way, whereas, in fact, there
17 are a great many people who are not taxpayers in Manitoba
18 who are not in the indigent group. We have some sons at
19 University and there is no reason in the world the State
20 should be paying their premiums, but they are listed as
21 non-taxpayers, and there must be a great many like that
22 who are today dependents on someone who is a taxpayer,
23 and that a more searching inquiry as to the group who
24 really do constitute needy cases would probably cut it
25 down substantially -- at least, I think it would if it
26 were gone at in a hardheaded way. There are probably many
27 people in Manitoba where their actual cash incomes may not
28 be unduly high, but who could come in for far less than
29 was estimated under the Medical Association's plan. I
30 think it was a most forceful approach and done under
considerable pressure, and I would guess the 5.7 million
was perhaps a rather outside figure, and if one were to
pursue that approach with greater firmness and a desire to



230,000,000. I believe they said it would represent about 25% of the population who would receive some form of assistance, and that seems reasonable in relation to Medicare costs plus this 25.7 million or 27,000,000. That is about 25% of the estimate of 328,000,000 or 323,000,000.

MR. KILGOUR: I would suspect that that

figure is probably considerably higher than a detailed

examination would confirm, because one can only get a figure such as they did by getting some negative figures. You say that there are so many taxpayers, and conversely that other people are not taxpayers, and you try to fill up the population in that way, whereas, in fact, there

are a great many people who are not taxpayers in Manitoba who are not in the indigent group. We have some sons at University and there is no record in the world the State should be paying their premiums, but they are listed as non-taxpayers, and there must be a great many like that who are today dependents on someone who is a taxpayer, and that a more searching inquiry as to the group who really do constitute needy cases would probably cut it down substantially -- at least, I think it would if it were gone at in a hardheaded way. There are probably many people in Manitoba where their actual cash incomes may not be unduly high, but who would come in for far less than was estimated under the Income Association's plan.

I think it was a most hopeful approach and does under considerable pressure, and I would guess the 2.7 million was perhaps a rather outside figure, and it was wise to pursue that approach with a degree of firmness and a desire to



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3 set it up on a plan where the State is not paying for
4 anyone who can pay for himself, it may be less.

5 COMMISSIONER VAN WART: The 25% included the 2
6 through the indigents, which would make it 20%, according
7 to his figures in the grey areas -- the semi-indigents.

8 MR. KILGOUR: There may be quite a lot
9 that are not; I don't know how complete our tax collection
10 system is -- how many people in one family are working
11 and producing a substantial gross income.

12 COMMISSIONER VAN WART: Students over 18
13 pay the hospital tax.

14 MR. KILGOUR: Yes. The State does not pay
15 it for them because they haven't got taxable income.

16 COMMISSIONER McCUTCHEON: I take it from
17 what you have been saying, Mr. Kilgour, in this discussion,
18 that you shrink from defining accurately what a person can
19 afford, and what a person can afford depends to a large
20 extent on the individual choices the person makes. You
21 may be able to afford a very expensive motor car and not
22 be able to afford to pay your hospital or medical bills.

23 MR. KILGOUR: Many people do conclude to
24 do that.

25 COMMISSIONER McCUTCHEON: That is what you
26 mean when you say you want a pretty searching examination
27 made of this area before you conclude who should or
28 should not be in it?

29 MR. KILGOUR: Yes, I think the concept of
30 need is one which the Chamber would subscribe to. I
31 think the business of need would take a very searching
32 inquiry, which one should always have if they are devoting



not paying for

anyone who can pay for himself, it may be less.

COMMISSIONER McCUTCHON: The 185 included in

to his figures in the past years -- the same thing.

MR. KILGORE: There may be quite a lot

that are not; I don't know how complete our tax collection

system is -- how many people in our family are working

and producing a substantial gross income.

COMMISSIONER VAN WART: Figures over 18

pay the hospital tax.

MR. KILGORE: Yes. The State does not pay

it for them because they haven't got taxable income.

COMMISSIONER McCUTCHON: I take it from

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that you shrink from defining accurately what a person can

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be able to afford to pay your hospital or medical bills.

MR. KILGORE: Many people do conclude to

COMMISSIONER McCUTCHON: That is what you

mean when you say you want a pretty searching examination

made of this area before you conclude who should or

should not be in it?

MR. KILGORE: Yes, I think the concept of

industry, which one should always have if they are devoting



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3 public money to provide some benefit.

4 THE CHAIRMAN: Because under the present
5 tax structure you could have a considerable income, in a
6 certain category as high as \$10,000, without being taxable?

7 COMMISSIONER McCUTCHEON: It depends on
8 the source of your income.

9 THE CHAIRMAN: Where the tax is paid at
10 source.

11 MR. KILGOUR: I suspect there would be
12 techniques of determining who are the individuals or the
13 brackets in which the State should recognize them as
14 being in need, and probably it may be considerably less
15 than the 20 or 25% figure that one arrived at by netting
16 some economic data.

17 COMMISSIONER BALTZAN: Mr. Hunter and
18 gentlemen, unfortunately I am one of those unfortunate
19 people who has to have a computer brain when dealing with
20 figures -- I am speaking of numerical figures; percen-
21 tages and statistical calculations. There has been some
22 considerable focus of attention on your part in connection
23 with national productivity, and then the opposite proposi-
24 tion was the effect of health in connection with national
25 productivity. As business people have you any estimates
26 of the relative loss of time by workers due to sickness
27 or, say, poor health coupled with that, because of ineffi-
28 cient or insufficient medical care, as compared with loss
29 of working hours due to industrial accidents -- lack of
30 preparation on the part of industries in that connection
-- as compared with strictly industrial accidents causing
workers loss of time?



public money to provide some benefit.

THE CHAIRMAN: I assume under the present

tax structure you could have a considerable income, in a

certain category as high as \$10,000, without being taxable

COMMISSIONER McCUTCHON: It depends on

the source of your income.

THE CHAIRMAN: Where the tax is paid at

MR. KILGORE: I suspect there would be

techniques of determining who are the individuals on the

brackets in which the State should recognize them as

being in need, and probably it may be considerably less

than the 20 or 25 figure that one arrived at by setting

some economic data.

COMMISSIONER BROWN: Mr. Foster and

gentlemen, unfortunately I am one of those unfortunate

people who has to have a computer in his office when dealing with

figures -- I am speaking of a meritorious figure; person-

ages and statistical calculations. There has been some

considerable focus of attention on your part in connection

with national productivity, and then the opposite, opposi-

tion was the effect of health in connection with national

productivity. As business people have you any estimates

of the effect of health on productivity?

or, say, poor health or old with that, because of ineffi-

cient or inefficient work, as compared with loss

of working hours due to industrial accidents -- loss of

operation or the loss of production in that connection

workers loss of time?



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4 I am putting a number of questions and I
will tie it up in a minute.

5 I spoke of sickness and its natural
6 history versus these cases that also cause sickness not
7 by the natural course of events but due to negligence,
8 carelessness, on the part of the individual, due to
9 industrial accidents because of poor preparation for a
10 working area. Things due to road accidents, the trauma-
11 tic things that are happening today. That is also cutting
12 down the work hours of people and their contribution
towards the nation's material needs.

13 Lastly, I think there is some connection,
14 I think I could go on quite a long time, to abuses and
15 indulgences on the part of those who go perhaps to too
16 many parties and have too much of the things that go with
17 parties and, say, drug addiction. I bring this in for
18 your consideration and, as I say again, you are covering
19 a wide territory, covering a majority of interests.
20 While stress is being placed on sickness as one of the
21 factors that tend to reduce the national productivity
22 there is then sickness not due to natural causes, as I
23 already outlined, from certain other factors. Those are
24 not necessarily things that are due to inadequate medical
25 care or inability to obtain medical care except after the
26 event. There are other competing factors with this quick
statement about poor health of the people due to natural
causes.

27 I would like, if it is possible and perhaps
28 there are also statistics to that effect, and if so, I am
29 sure it would be most valuable to the Commission. I hope
30

I am putting a number of questions and I will tie it up in a minute.

I spoke of sickness and its natural history versus these cases that also cause sickness not by the natural course of events but due to negligence, carelessness, on the part of the individual, due to industrial accidents because of poor preparation for a working area. Things due to road accidents, the things that are happening today, that is also cutting down the work hours of people and their contribution towards the nation's material needs.

Lastly, I think there is some connection, I think I could go on quite a long time, to abuses and indulgences on the part of those who go perhaps to too many parties and have too much of the things that go with parties and, say, drug addiction. I bring this in for your consideration and, as I say again, you are covering a wide territory, covering a majority of interests. While stress is being placed on sickness as one of the factors that tend to reduce the national productivity there is then sickness not due to natural causes, as I already outlined, from certain other factors. Those are not necessarily things that are due to inadequate medical care or inability to obtain medical care except after the statement about poor health of the people due to natural causes.

I would like, if it is possible and perhaps there are also statistics to that effect, and if so, I am sure it would be most valuable to the Commission. I hope



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4 I have made my point that we are talking too much about
5 sickness without breaking it down and classifying it.
6 Admittedly with sickness if it was avoided and improved
7 then your point would be well taken that productivity
8 certainly would be improved by improvement of the indivi-
9 dual's lack of good health. So, while that is not a
10 question I place it before you to see if possibly you may
11 in the future help us out in connection with these contri-
12 butory factors.

13 Let me ask you this: has productivity
14 increased because of two demonstratable things of the
15 past decade? You are probably acquainted with the fact
16 that more people have been liberated from mental institu-
17 tions and mental cases are fewer requiring institutional
18 care and have been rehabilitated. There is an incidence
19 of more people becoming rehabilitated and one would
20 therefore expect that they are working then or able to
21 take care of themselves and able to produce. Perhaps
22 the number is not sufficient but if it is true that the
23 health of the people has improved this should also show
24 itself at the opposite end of working hours and production.
25 Am I right in making that contention? If I am not clear
26 I will restate it.

27 MR. KILGOUR: I certainly am not familiar
28 enough to add any statistics to the point you raise. I
29 think on the question of productivity in the Province of
30 Manitoba where you have as high as 70% of the people in
Winnipeg covered you can probably say that most of
industry in Manitoba does have medical care and we are
therefore getting that contribution of productivity.



I have made no point that we are talking too soon about
illness without passing it down and classifying it.
Admittedly with illness it is avoided and improved
then your point would be well taken that productivity
certainly would be improved by improvement of the individ-
ual's lack of good health. So, while that is not a
question I place it before you to see if possibly you say
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Let me ask you this: Has productivity
increased because of two demonstrable things of the
past decades? You are probably acquainted with the fact
that more people have been liberated from mental ill-ness-
tions and mental cases are fewer regarding institutional
cases and have been rehabilitated. There is an indication
of more people becoming rehabilitated and are doing
therefore expect that they are working more or able to
take care of themselves and able to produce. Perhaps
the number is not sufficient but it is true that the
health of the people has improved this should also show
itself at the opposite end of working hours and production

I will restate it.

MR. KILGORE: I certainly do not believe

enough to add any statistics to the point you raised. I
think on the question of productivity in the provinces of
Minnesota where you have as high as 75% of the people in
mining covered you can probably say that most of
industry in Minnesota does have excellent health and we are
therefore getting that contribution of productivity.



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3 COMMISSIONER BALTZAN: There are two
4 factors, the fact that people whose health has improved
5 and have been rehabilitated are placed in the field of
6 productivity and the result is it has increased producti-
7 vity because they have been liberated into the working
8 field. The same thing may be said of tuberculosis, there
9 are few people now in institutions.

10 THE CHAIRMAN: Dr. Baltzan, I do not like
11 to interfere with your questioning but the purpose of the
12 inquiry is for these gentlemen to add to our knowledge,
13 perhaps more so than we should teach some of the economic
14 factors to these gentlemen who are already experts.

15 COMMISSIONER BALTZAN: I understand. I
16 am very conscious of that and I do not say anything here
17 to embarrass. I do feel that we could expect, certainly
18 to my knowledge, that we might have a better understanding
19 of the general term of what has been emphasized here. It
20 has been admitted that sickness is very often serious and
21 costly but it is a very sweeping word and there are other
22 factors that should be considered in the same connection,
23 contributory factors. I repeat, just to leave off at
24 this point, there are contributory elements of negligence,
25 carelessness, industrial factors, road accidents, abuses
26 of all kinds and it is not all a question of sickness
27 being due to inadequacy of good medical care.

28 MR. KILGOUR: Automobiles contribute more
29 people than half the medical profession can alleviate.

30 COMMISSIONER BALTZAN: In other words, you
partly agree with me.

THE CHAIRMAN: Are there any other questions,

COMMISSIONER WALKER: There are two

and have been rehabilitated are placed in the field of productivity and the result is it has increased productivity because they have been liberated into the working field. The same thing may be said of tuberculosis, there are few people now in institutions.

THE CHAIRMAN: Dr. Altman, I do not like to interfere with your questioning but the purpose of the inquiry is for these gentlemen to add to our knowledge, perhaps more so than we should teach some of the economic factors to these gentlemen who are already experts.

COMMISSIONER WALKER: I understand, I am very conscious of that and I do not say anything more to emphasize. I do feel that we could expect certain to my knowledge, that we might have a better understanding of the situation. It has been admitted that sickness is very often serious and factors that should be considered in the same connection, contradictory factors. I repeat, please to leave out

being due to inadequacy of good medical care. DR. KILGUS: Automobiles contribute more people than half the medical profession can relieve.

partly agree with me.



gentlemen? Thank you very much, gentlemen. This has added greatly, this discussion on the economic involvements and principles, has added a great deal to the factors we will have to take into consideration in due course.

THE CHAIRMAN: Next submission is that of Dr. Alan A. Klass.

THE SECRETARY: This will be Exhibit No. 67.

--- EXHIBIT NO. 67: Submission of Dr. Alan A. Klass.

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to test of submission is that of

Alan A. Glass,

THE SHOWSTAY: This will be Exhibit 10.

EXHIBIT NO. 87: Submission of Mr. Alan



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4 SUBMISSION OF DR. ALAN A. KLASS

5 THE CHAIRMAN: You have a submission you
6 would wish to make to us in connection with the organiza-
7 tion of crafts and professions?

8 DR. KLASS: Sir, prior to making the
9 submission may I correct an error for which I am entirely
10 responsible. I notice that in the press announcements
11 and, indeed, in the program of presentation set out by
12 your Secretary, because of a semantic problem, my submis-
13 sion is put down under the heading of "Organizations".
14 I know of no organization of crafts and professions and
15 if there is one I am the only member of it.

16 THE CHAIRMAN: So your submission will be
17 a unanimous one?

18 DR. KLASS: That is right, sir.

19 The views expressed herein are those of the
20 author and do not necessarily represent either the opinions
21 of any professional organization with which he is associ-
22 ated -- nor the views of other members of the profession.
23 Nor on the other hand is there reason to consider these
24 views as a "minority opinion".

25 I. Function and Organization of Crafts

26 In organized society individuals have two
27 kinds of basic needs: one is fulfilled by a craft; the
28 other by a profession. In view of statements made sugges-
29 ting an alteration in the structure of the medical profes-
30 sion by experts in the organization of crafts, it may be
advisable to review some of the distinctions.

Crafts build the physical structure of
society. They provide food, clothing and shelter,



THE CHAIRMAN: You have a submission you would wish to make to us in connection with the organization of crafts and professions?

submission may I correct an error for which I am entirely responsible. I notice that in the press announcements and, indeed, in the program of presentation set out by the organization, the heading of "crafts and professions" is put down under the heading of "occupations". I know of no organization of crafts and professions and if there is one I am the only member of it.

THE CHAIRMAN: So your submission will be a unanimous one?

MR. KUBER: That is right, sir. The views expressed herein are those of the author and do not necessarily represent either the opinion of any professional organization with which he is associated -- nor the views of other members of the profession. I am submitting these views as a "minority opinion".

I. Function and Organization of Crafts

I am submitting these views as a "minority opinion" in view of statements made elsewhere by a professional organization in the structure of the medical profession by experts in the organization of crafts, it may be advisable to review some of the distinctions. Crafts define the physical structure of society. They provide food, clothing and shelter.



perform the agriculture, and operate the commerce.
Craftsmen work under direction; their sphere of activity
can be accurately defined; their skills developed by 'on
job' experience, gained in a relatively short time.
Subject to prior negotiations, remuneration can be
determined on a weekly, hourly or 'piece-work' basis.
With adequate incentives, craftsmen work effectively and
efficiently within a master-servant or civil-service
relationship.

Crafts may be organized into Unions whose
officers exercise a measure of control over the individual
members but not to the degree of removing the members'
right to work in his craft. The statutory rights of
Unions have greatly improved the conditions of the worker
and in turn helped to create the high living standards
of Western society. While there may exist transient
abuses by certain Unions, nowhere in Western society is
there a respectable opinion that a substantial reduction
in their powers would be in the public interest. No
responsible medical group has expressed such a view.

II. Function and Organization of Professions

On the other hand, members of the medical
profession deal with individuals rather than with things.
"The three traditional professions: law, medicine and
the clergy, arose from a need for individuals acceptable
by the community, as competent to administer the spiritual
and corporal needs of the individual and to legalize and
regulate the disposal of his worldly goods". ("What is a
Profession?" - Klass: Appendix A)

Thus the educational requirements differ

Craftsmen work under discipline; their sphere of activity can be accurately defined; their skills developed by long job experience, gained in a relatively short time. Subject to prior negotiations, remuneration can be determined on a weekly, monthly or piece-work basis. With increased specialization, work becomes increasingly and efficiently within a narrow-boundary or civil-service relationship.

Officers exercise a measure of control over the individual members but not to the degree of removing the member's right to work in his state. The statutory rights of unions have greatly improved the conditions of the worker and in turn helped to ensure the high living standards of Western society. While there may exist tendencies abuses by certain unions, nowhere in Western society is there a respectable opinion that a substantial reduction in their powers would be in the public interest. No responsible medical group has expressed such a view.

11. Function and Organization of Professions

On the other hand, members of the medical profession deal with individuals rather than with groups. "The three traditional professions: law, medicine and the clergy, arose from a need for individuals responsible by the community, as compared to administering the affairs and corporate needs of the individual and to legislate and

Professions? - Kierkegaard's view

Thus the education, reputation, etc.



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3 considerably from a craft, and a course in University is
4 an absolute pre-requisite to entrance into a profession.
5 Admission into the medical profession in Manitoba can be
6 achieved only by fulfilling the rigid requirements set by
7 the statutory provisions of the College of Physicians and
8 Surgeons of Manitoba and by becoming subject to its
9 sanctions. (Medical Act of Manitoba)

10 III. Professional Obligations

11 The College of Physicians & Surgeons
12 (Manitoba) has evolved from a different set of conditions
13 than those which determine a Union organization. It is
14 important to recognize the distinctions.

15 The Medical Act of Manitoba provides that
16 in exchange for the exclusive right to practise medicine
17 (1) registered practitioners will submit to the following
18 obligations:

- 19 1. A course of study in an accepted
20 University for a period of not less than
21 seven years (2) (The University of Mani-
22 toba equivalent of an M.D. degree)
- 23 2. They will take further training for
24 not less than a year in an accepted
25 general hospital (3)
- 26 3. For recognition as specialists they
27 will furthermore pass an approved specialty
28 examination after an additional period of
29 training of not less than 4 years. (4)
- 30 4. While registered practitioners may
determine their own fee structure, this
privilege is always subject to review and



an absolute pre-requisite to entrance into a profession.
Admission into the medical profession in Manitoba can be
achieved only by fulfilling the right requirements set by
the statutory provisions of the College of Physicians and
Surgeons of Manitoba and by becoming subject to the
jurisdiction of the Medical Act of Manitoba.

III. Professional Obligations

The College of Physicians and Surgeons
(Manitoba) has evolved from a collection of conditions
than those which determine a Union of Physicians. It is
important to recognize the obligations.

The Medical Act of Manitoba provides that
in exchange for the exclusive right to practise medicine
(1) registered practitioners will submit to the following
obligations.

1. They will take an oath of office and subscribe to the following:
University for a period of not less than
seven years (2) The University of Manitoba
four equivalent or an M.D. degree)
2. They will take further training for
not less than a year in an approved
general hospital
3. For recognition as specialists they
will furthermore pass an approved specialty
examination and will be subject to the jurisdiction of the
College of Physicians and Surgeons of Manitoba.



correction by the Officers of the College of Physicians & Surgeons (Manitoba) (5)

5. Essential professional services cannot be refused on any grounds whatsoever without becoming subject to the charge of unprofessional conduct.

6. The right to treat a patient must be subject to standards of competence as determined by the College of Physicians & Surgeons (Manitoba) (6). Exaggerated ideas or methods are subject to disciplinary action.

7. The right to practise (i.e. to earn a living within the profession) can be removed by the College of Physicians & Surgeons (Manitoba) (7). "Doctors are struck from the rolls, lawyers disbarred, priests defrocked". This drastic action -- operating only within professional organizations -- may be taken on either professional or moral grounds. (8)

IV. The Quality of Medical Care

It is important to note that in all these controls, be they of remuneration, of competency or of morals, one agent only enters into the relationship between patient and doctor. That agent is the statutory based, democratically-elected College of Physicians & Surgeons. Whenever other agencies have assumed this function, there has resulted, to a greater or less degree, a deterioration in patient-doctor relationship, and an inevitable



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3 degradation in professional standards.

4 In spite of serious attempts to define
5 'quality' in medical care, and despite firm statements
6 supporting one or another system; the fact remains that
7 up to the present there is no scientific objective
8 measure of 'quality'. Given a competent doctor, it is
9 the state of his own individual conscience, his own indi-
10 vidual 'professional spirit' that determines the quality
11 of his medical care. It is for this reason that profes-
12 sional integrity, based upon the activity of its official
13 guardian, the College of Physicians & Surgeons (Manitoba)
14 is important in currently valid measures of 'quality'.

15 For all the above reasons, any approach
16 to the problem of improving medical care that tends to
17 approximate the conditions of a profession to that of a
18 craft, is probably wrong. A craft can be subject to the
19 terms of a civil service or to a master-servant relation-
20 ship: a profession never, without violating to some
21 degree the patient-doctor relationship. Even apparently
22 minor deviations from this relationship, as in various
23 insurance plans have created stresses and strains the
24 effect of which has compromised patient-doctor relation-
25 ship and reduced the quality of professional conduct.
26 Most insurance companies and so-called prepaid plans have
27 lists of doctors who have been suspected of real or
28 imagined transgressions of their ad hoc rules.

29 While it cannot be argued that without
30 third parties there are no transgressions, it is reasonable
to assume that among some members of the profession, the
existence of third parties creates the climate for non-

gebuhrliche Ländereinkommen zu



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3 professional conduct. The result is a reduction in
4 professional standards: the cause: third party interven-
5 tion.

6 And in summary I wish to state that the
7 aim of this presentation is to make the plea that whatever
8 changes are created in the system of medical care in
9 Canada, that the principle of professional control of
10 educational requirements, of discipline and of remuneration
11 be maintained.

12 THE CHAIRMAN: Thank you very much Dr.
13 Klass for this philosophical discussion and enunciation
14 of principles, and it has gone into our record and will
15 be before us in our later consideration of the problem.

16 The Association for Retarded Children in
17 Greater Winnipeg.
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tion.

And in summary I wish to state that the aim of this presentation is to make the plan that whatever changes are created in the system of medical care in Canada, that the principle of professional control of educational requirements, of discipline and of remuneration be maintained.

THE CHAIRMAN: Thank you very much, Dr. [Name] for this philosophical discussion and enumeration of principles, and it has gone into our record and will be before us in our later consideration of the proposal.



SUBMISSION OF THE ASSOCIATION FOR RETARDED

CHILDREN IN MANITOBA

Appearances: Mr. M.G. McKenzie
Mr. D.C. Dobbin
Mr. Peter Wilby

MR. WILBY: Mr. Chairman, I will be the spokesman, and if there are any questions I cannot answer, we have with us the President of the Greater Winnipeg Association and the President of the Manitoba Association.

This is a brief actually on behalf of the Manitoba Association, not the Winnipeg Association. Would you like us to read the brief?

THE CHAIRMAN: Yes. This will be No. 68, and if you will read perhaps your summary and your recommendations, then we may have a discussion which will bring out the salient parts of your brief itself.

--- EXHIBIT NO. 68: Submission of The Association for Retarded Children in Manitoba.

MR. WILBY: The Association for Retarded Children in Manitoba has been responsible for the creation of community programmes for the mentally retarded. It was originally intended that many of such programmes should be pilot projects which, when their need and value was proven, would become the responsibility of other established authorities. In less than a decade requirements and demands for services have grown so rapidly that the Association has become involved in province-wide projects of increasing proportions.

Decisions have yet to be made to establish



SUBMISSION OF THE ASSOCIATION FOR RETARDED

CHILDREN IN MANITOBA

Mr. D.C. Dobbin

MR. WILBY: Mr. Chairman, I will be the

spokesman, and if there are any questions I cannot answer,

we have with us the President of the Greater Winnipeg

This is a brief actually on behalf of the

Manitoba Association, not the Winnipeg Association.

Would you like us to read the brief?

THE CHAIRMAN: Yes. This will be No. 88.

and if you will read perhaps your summary and your recom-

mendations, then we may have a discussion which will

bring out the salient parts of your paper itself.

--- EXHIBIT NO. 88: Submission of The Association for
Retarded Children in Manitoba.

MR. WILBY: The Association for Retarded

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of community programmes for the mentally retarded. It

was originally intended that many of such programmes should

be pilot projects which, when their need and value was

proven, would become the responsibility of other estab-

lished authorities. In less than a decade requirements

and demands for services have grown so rapidly that the

Association has become involved in province-wide projects

of increasing proportions.

Decisions have yet to be made to establish



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4 ultimate responsibilities of programming and financing of
5 community facilities for the care and training of mental
6 retardates of all ages. The chief authorities involved
7 are: Health, Welfare, Education, Rehabilitation, Labour
8 and Recreation.

9 The numbers of mental retardates of all
10 ages and different categories are larger than generally
11 supposed.

12 Recommended community facilities are:

13 (a) Diagnostic and Counselling Centres
14 providing services on behalf of the
15 infant, child and adult retardate, and
16 for those responsible for him.

17 (b) Pre-school nursery facilities.

18 (c) Day training classes.

19 (d) Recreational-Occupational training
20 classes.

21 (e) Sheltered Workshops.

22 (f) Community Residential Units.

23 (g) Short-Stay Residential Facilities.

24 (h) Community Recreational Facilities.

25 Inter-departmental Boards are necessary to
26 investigate, create and co-ordinate the work of the
27 different facilities and services required.

28 Provincial endeavours need Federal assis-
29 tance. In this connection there are three
30 initial suggestions:

(a) That serious consideration should be
given to the organizing and financing of a
national survey on the incidence of mental



ultimate responsibility of programming and financing a community facilities for the care and training of mental patients. The program should be designed to provide a continuum of care from the hospital to the community and recreation.

The program of mental patients of all ages and different abilities and needs should be developed.

- (a) Diagnostic and Counseling Centers providing services on a basis of the patient, child and adult patients, and for those who are in the hospital.
- (b) Group and nursery facilities.

(c) Educational and vocational training.

- (d) Sheltered workshops.
- (e) Community centers and clubs.

Interdepartmental efforts are necessary to the work of the

provision of mental health services. In this connection there are three

that are of importance in the field of



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3 retardation by the Federal Government.

4 (b) That serious consideration should be
5 given to the setting up of standards for
6 Government Training Schools and Institu-
7 tions for the mentally retarded and that
8 the present per capita grant system to
9 such facilities should be reviewed and
10 revised to enable Institutions to more
11 thoroughly perform their many different
12 kinds of health services.

13 (c) That Mental Deficiency Grants be made
14 available to assist the provinces in an
15 extended programme for the prevention
16 and treatment of mental handicap in children.

17 THE CHAIRMAN: Now, is there something that
18 you would like to add by way of explanation, or expansion
19 of what you have said?

20 MR. WILBY: Well, there are one or two
21 items I can perhaps enlarge upon, sir. In talking of the
22 different responsibilities, we mentioned the authorities.
23 When we come to retardates in their late teens, there is
24 a very definite problem here now in providing work for
25 them, either employment in the community or in sheltered
26 workshops. Whose responsibility it is to provide this
27 work, or the sheltered workshops is not determined yet.
28 The Children's Society did begin and took in some
29 mentally retarded, but they have had to curtail this.
30 Whether this should be the responsibility of this Associa-
tion, to provide the service, has not yet been settled.
Children in the lower bracket of the educable group, who



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3 are in special classes in the public schools are leaving
4 school at 16, 17 years of age, and these children cannot
5 find, or hope for, employment, so that when you get up to
6 this stage there are many different authorities dealing
7 with these children who are really involved, and who
8 should accept the responsibility of such-and-such a
9 point for providing programs for them has not been deter-
10 mined.

11 In the matter of -- in the brief, I have
12 not mentioned this very much in the summary, but in the
13 same way we feel that the matter of training classes for
14 training the mentally retarded, the system of financing
15 these programs has not yet been determined. It is more
16 on a philosophical plan. These children are not considered
17 educable. They are really not the responsibility of these
18 schools.

19 THE CHAIRMAN: Would you just tell us just
20 what is the present program for that group?

21 MR. WILBY: Yes sir. We have day classes
22 in the province in 17 centres. These day centres provide
23 training classes. The aims are to promote as far as
24 possible the educational achievement of these children,
25 but this is very minor, and the point I am trying to make
26 is, is this an educational problem or a health and welfare
27 problem?

28 THE CHAIRMAN: These are the non-educable
29 group?

30 MR. WILBY: These are what are usually
referred to as the trainable group. I.Q.'s under 50,
down to 30. The problem they create is just as much a

7 with these children who are really involved, and who
8 should accept the responsibility of such an action
point for providing programs for them has not been before
mines.

In the matter of -- in the first, I have
not mentioned this very much in the summary, and in the
same way we feel that the matter of creating classes for
training the mentally retarded, the system of financing
these programs has not yet been determined. It is now
on a philosophical plan. These children are not considered
educable. They are really not the responsibility of these
schools.

THE CHAIRMAN: Would you just fill us in

what is the present program for that group?

MR. ALLEN: Yes, sir. We have day classes
in the province in 17 schools. The day classes provide
training classes. The classes are to provide as much as
possible the educational achievement of these children,
but this is very hard, and the school is trying to take
the children out of the home and put them in the school.
The children are to be placed in the home as much as possible.

Group?

MR. ALLEN: Yes, sir. And while we usually
referred to as the "training school" (I) "a school" is



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3 health and welfare problem as an educational problem.

4 THE CHAIRMAN: What contribution comes
5 from government for that?

6 MR. WILBY: It is listed in Appendix C.
7 We get grants from the Department of Health in Manitoba
8 at the moment, \$200 per child per year. The grant is
9 based on percentage of attendance. Then we get a grant
10 from the municipal governments. In Winnipeg we take
11 children from Greater Winnipeg, so whichever municipality
12 the child comes from, the municipal government pays \$125
13 per child per year making a total of \$325. The Provincial
14 grant is based on attendance. We get the full amount for
15 attendance over 85%. The average cost for providing
16 these programs is \$500 per child per year, so that the
17 Association itself has to raise about \$185 per child
18 per year. This takes into account the lesser amount
19 because of the percentage provincial grant, and we know
20 that the Association's activities therefore include fund
21 raising, and one of the problems that the Association is
22 now running into, since for every child it takes in it
23 has to raise \$185, we are having considerable difficulty
24 in meeting our portion.

25 THE CHAIRMAN: Who has provided the physical
26 facilities, the buildings, and equipment?

27 MR. WILBY: These have been provided
28 through public donation, largely through fraternal and
29 service organizations. In Winnipeg the Kinsmen Club
30 raised the money and built the school. It is only four
years old, and one addition was necessary a year later,
and we are planning another addition this Spring.



health and welfare problem as an educational problem.

THE CHAIRMAN: What contribution comes

from government for that?

MR. ALDAY: It is listed in Appendix C.

We get grants from the Department of Health in Lansing

at the moment, \$230 per child per year. The grant is

based on percentage of attendance. Then we get a grant

from the municipal government. In Winthrop we take

children from Greater Winthrop, as Winthrop municipality

the child comes from, the municipal government pays \$185

per child per year making a total of \$415. The Provincial

grant is based on attendance. We get the full amount for

attendance over 85%. The average cost for providing

these programs is \$200 per child per year, so that the

Association itself has to raise about \$185 per child

per year. This takes into account the lesser amount

because of the percentage provincial grant, and we know

that the Association's activities therefore include fund

raising, and one of the problems that the Association is

now running into, since for every child it takes to be

has to raise \$185, we are having considerable difficulty

in meeting our position.

MR. ALDAY: The fee provided for the program

is \$185 per child per year.

MR. ALDAY: I have been providing

through public subscription, largely through fraternal and

service organizations. In winning the Kansas City

raised the money and built the school. It is only four

years old, and one addition was necessary a year later,

and we are planning another addition this coming



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3 COMMISSIONER STRACHAN: What about the
4 other schools?

5 MR. WILBY: In the same way, they have
6 raised money locally, largely through the system of
7 fraternal organizations. In some places they simply rent
8 a room in a school or public hall.

9 THE CHAIRMAN: What contribution, if any,
10 comes from school boards?

11 MR. WILBY: None.

12 COMMISSIONER STRACHAN: Do they actually
13 charge rental for the use of a room in a public school
14 for the instruction of retardates?

15 MR. WILBY: Not that I know of. I might
16 point out that I believe in all the other provinces in
17 Canada Associations for Retarded Children get their
18 grants from education ---

19 THE CHAIRMAN: Certainly in some of them.
20 I don't know if it applies to all. Are you familiar with
21 the organization, say, of the John Dolan School in Saska-
22 toon?

23 MR. WILBY: I know of it.

24 THE CHAIRMAN: And the manner in which it
25 is operated?

26 MR. WILBY: They operate on a slightly
27 different basis. Their Board consists of people from
28 the Department of Education and from business and so on,
29 and the operation is run through this Board. Our Board
30 is a little different. Our system of financing is
different.

THE CHAIRMAN: I appreciate that, but has

COMMISSIONER: What about the

in the same way, they have

raised money locally, largely through the system of fraternal organizations. In some places they simply rent a room in a school or public hall.

THE CHAIRMAN: What conditions, or, say,

comes from school boards?

MR. WILBY: None.

COMMISSIONER: Do they actually

charge rental for use of a room in a public school for the instruction of students?

MR. WILBY: Not that I know of. I might

point out that I believe in all the other provinces in Canada Associations for Retarded Children get their

grants from education --

THE CHAIRMAN: Certainly in some of them.

I don't know if it applies to all. Are you familiar with the organization, say, of the John Dutton Fund, in Quebec?

THE CHAIRMAN: And the manner in which it

is operated?

MR. WILBY: They operate on a slightly

different basis. Their board consists of people from the Department of Education and from business and so on, and the organization is run through this board. Our board is a little different. Our system of financing is

different.

THE CHAIRMAN: I appreciate that, but are



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4 an effort been made to have the educational authorities,
5 that is the School Boards, accept the proposition that
6 if these children were not retarded they would be in the
7 school population, and would cost X dollars a year to
8 educate, and that that source of revenue, which they are
9 not required to spend because the child is not in the
10 school, have it directed towards the special school.

11 Now, I think that is the basis of the John Dolan School
12 and the Harrow deGroot School in Regina, and the provin-
13 cial system there of recognizing the educational responsi-
14 bility as belonging to the educational authority.

15 MR. WILBY: This point has been brought
16 up several times of course in the past few years, and
17 when we present our briefs to the Manitoba Government,
18 we usually present them jointly to the Minister of Health
19 and the Minister of Education, so that the Department
20 of Education is well aware of our whole situation.

21 THE CHAIRMAN: I was wondering if this
22 grant of \$125 was in lieu of that figure that would come
23 from the School Board, although \$125 is much below the
24 average cost of educating a pupil in the public school system
25 of either Manitoba or any other western province.
26 Roughly \$200 is the round figure.

27 MR. WILBY: I don't think this grant, as
28 a matter of fact a recent occurrence involving one munici-
29 pality at least as to granting this sum of money to us
30 makes us presume that the grant is rather a form of chari-
table donation under the Municipal Act. The municipalities
under the Act may donate sums of money for charitable
purposes. There is a question as to whether or not we



...the ... of ...

if these children were not retarded they would be in the school population, and would cost \$1 dollar a year to educate, and that that source of revenue, which they are not required to spend because the child is not in the school, have it directed towards the special school. Now, I think that is the basis of the John Dolan School and the Harrow district school in Ontario, and the provincial system there of recognizing the educational responsibility as belonging to the educational authorities.

MR. WILBY: This point has been brought up several times of course in the past few years, and what we present our advice to the Legislature Government, we usually present them jointly to the Minister of Health and the Minister of Education, so that the Department of Education is well aware of our whole situation. THE CHAIRMAN: I was wondering in this

from the school board, although it is not within the average cost of educating a child in the public school system. ... Minister on any other western province.

roughly \$200 is the normal figure. MR. WILBY: I don't think that figure is a matter of fact a recent occurrence involving the Ministry at least as to giving this to the ...

table donation under the Mental Health Act. The municipal ...



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3 are entitled to this under that.

4 THE CHAIRMAN: Is there a program for the
5 identifying of retardate children below school age?
6 Generally they pretty well come to school age and the
7 differentiation is made, but prior to that, what program
8 is there here in Manitoba to identify those who will
9 ultimately come into this group of the trainable but not
10 educable?

11 MR. WILBY: There is not a program sir
12 that we know of. Of course, in Winnipeg there are clinics
13 such as the clinic in the Children's Hospital and other
14 hospitals. The more retarded children are identified
15 at a very early age, and are given examinations by
16 medical doctors, psychiatrists, and so on, but there is
17 no program for these children, and I think we mention in
18 this brief that we feel a definite need for a pre-school
19 program, and also for a central clinic, or probably more
20 than one, in the province, to which these children could
21 be brought, so that the whole assessment on educational
22 and psychiatric bases can be made. What happens now is
23 that a mother goes to one centre and to another and to
24 another, and there is a lot of duplication.

25 COMMISSIONER VAN WART: Is there a program
26 in your organization in co-operation with the medical
27 profession in trying to identify these retarded children,
28 phenylketonuria, and they can be taken and cured from
29 the retarded class?

30 MR. WILBY: This matter of phenylketonuria
has been discussed recently with the Department of Health.
The Canadian Association is trying to get legislation

are entitled to this under that.

THE CHAIRMAN: Is there a program for the

identifying of retarded children below school age?

Generally they pretty well come to school age and the differentiation is made, but prior to that, what program is there here in Manitoba to identify those who will ultimately come into this group of the trainable but not educable?

MR. WILBY: There is not a program at that we know of. Of course, in Winnipeg there are clinics such as the clinic in the Children's Hospital and other

this brief that we feel a definite need for a pre-school program, and also for a central clinic, or probably more than one, in the province, to which these children could be brought, so that the whole assessment on educational and psychiatric bases can be made. What happens now is that a mother goes to our house and to another and to another, and there is a lot of duplication.

in your organization in cooperation with the local profession is trying to identify these retarded children, and they can be taken and moved from

has been discussed recently with the department of health. The Canadian Association is trying to get legislation



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3 across the country, so that testing for this condition
4 will be done automatically shortly after birth, and the
5 Government will provide funds for the special diet, at
6 least in part. This has been brought up fairly recently,
7 and I believe the Government of Manitoba is trying to
8 look after this.

9 THE CHAIRMAN: But that is not being done
10 automatically in the hospitals now, this testing is not
11 being done automatically?

12 MR. McKENZIE: We have been in touch with
13 the Department of Health about that, and through the
14 Medical Association they have recommended to all doctors
15 that this test be automatic. Whether or not it is
16 actually being carried out I cannot say, but there is a
17 definite recommendation that it be done.

18 THE CHAIRMAN: And the test having been
19 made, and say it is found to be positive, have you any
20 program that goes on from there?

21 MR. McKENZIE: Actually I have yet to hear
22 of a positive case in Manitoba.

23 MR. WILBY: We do have cases at the Kinsmen
24 School in Winnipeg, two or three suffering from this
25 condition, but they were not identified, and I don't think
26 they are on a special diet. I do understand that even
27 though you do not catch this condition early, if you put
28 the child on a diet even at a late date it will help.

29 THE CHAIRMAN: Up to about five years of
30 age I understand.

MR. WILBY: Well, I understood from the
Superintendent at the Manitoba School, I think he



across the country, so that testing can take place
will be done automatically shortly after birth, and the
Government will provide funds for the special diet, at
least in part. This has been brought up fairly recently,
and I believe the Government of Manitoba is trying to
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THE CHAIRMAN: But that is not being done
automatically in the hospitals now, this testing is not
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MR. McNEIL: We do have cases at the Winnipeg
School in Winnipeg, two or three suffering from this
condition, but they were not identified, and I don't think
they are on a special diet. I do understand that even
though you do not catch this condition early, it can be
the child of a mother even on a late date is still born.

THE CHAIRMAN: Up to about five years of
age I understand.
Well, I understand from the
Superintendent at the Manitoba School, I think it



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3 mentioned not too long ago that even at older age levels
4 he believed that this diet would bring out the best
5 there was remaining in a child.

6 THE CHAIRMAN: You say it is expensive.
7 The figure given to us in Halifax was, to take a child
8 in infancy, it would cost about \$4,000.

9 MR. WILBY: Well, our figure, the one we
10 had some time ago, was considerably more than this, and
11 at that time we have never been told definitely how long
12 this diet must be continued.

13 THE CHAIRMAN: That was the figure given
14 us in the hearings from the research being done under
15 the auspices of Dalhousie University.

16 MR. WILBY: Well, we certainly would not
17 dispute that. Coming back to pre-school children, we do
18 want to start a pre-school facility, possibly taking
19 these children in at 3 or 4 years of age, and there is
20 considerable evidence available from the medical profes-
21 sion that this would help a great deal, and also would
22 help the parents, and in the matter of counselling
23 parents, and so on, this Association has had to do this.
24 I think it is a fair criticism to say that the parents
25 of young retarded children are not given the support and
26 advice and so on that they really need, and with a lot
27 of help they become very efficiently involved.

28 THE CHAIRMAN: Is there any organization
29 or any provision for help being given in a family where
30 there is a child of this nature?

MR. WILBY: Help is given through the
public health unit to some extent, particularly out in the



there was remaining in a child.

THE CHAIRMAN: You say it is expensive.

The figure given to us in Halifax was, to take a child in infancy, it would cost about \$4,000.

MR. WILBY: Well, our figure, the one we had some time ago, was considerably more than this, and at that time we have never been told definitely how long this diet must be continued.

THE CHAIRMAN: That was the figure given

us in the hearings from the research being done under

the auspices of Dalhousie University.

MR. WILBY: Well, we certainly would not dispute that. Coming back to pre-school children, we do want to start a pre-school facility, possibly taking these children in at 3 or 4 years of age, and there is considerable evidence available from the medical profession that this would help a great deal, and also would help the parents, and in the matter of counselling parents, and so on, this Association has had to do this.

advice and so on that they really need, and with a lot of help they become very efficiently involved.

THE CHAIRMAN: Is there any organization

or any provision for help being given in a really where there is a child of this nature?

MR. WILBY: Help is given through the

public health unit to some extent, mostly in the



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4 country. In Winnipeg the Association has recently taken
5 on a social worker, and this is her main job -- to be a
6 guidance counsellor. But we can fill the need, but we
7 don't have the money.

8 THE CHAIRMAN: Besides the guidance, is
9 there any physical help?

10 MR. WILBY: No.

11 COMMISSIONER GIRARD: Do you have any of
12 the sheltered workshops that are used here, that are
13 functioning?

14 MR. WILBY: No. About two years ago the
15 Society for Crippled Children and Adults running their
16 industrial workshop agreed on a trial basis to take in
17 some few mentally retarded. This has been discontinued.
18 At the present time they are not taking in any. I don't
19 know whether the main reason is for lack of money or that
20 they didn't feel that the mentally handicapped could work
21 side by side with the physically handicapped.

22 COMMISSIONER GIRARD: When you did have
23 workshops was there a screening process to find out which
24 ones were the type that would benefit by the workshops?

25 MR. WILBY: Yes, the Society for Crippled
26 Children and Adults did the screening. We referred some
27 children. Others were referred directly by parents to
28 the Society, and when the project first started I believe
29 they had about twelve mentally retarded in there, but
30 these were not mentally retarded at the level of the day
training classes. Most of them were in the educable
bracket. But, as I say, they have discontinued this and
our Association is very anxious to see a workshop started.



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THE CHAIR

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our Association is very anxious to see a workshop started.



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4 MR. DOBBIN: May I speak a little further
5 on the question of workshops? We do not have one, not
6 because we don't believe in them or are not interested;
7 they are definitely the next stage on the program -- we
8 are operating now what we call an operational centre for
9 older retardees, and out of this will grow our first work-
10 shop. We are operating in rented quarters at this time,
11 and the addition we propose to build this coming Spring
12 to have ready for September will be used initially as an
13 occupational centre and the pilot project of our sheltered
14 workshop. I think the reason that the combined mentally
15 retarded and physically handicapped working together in
16 one workshop didn't work out as planned was that it was
17 an industrial workshop and not a sheltered workshop. The
18 great majority of our children who are fit candidates for
19 workshops will definitely require the sheltered conditions.
20 Also, we had not had the preparation of these first candi-
21 dates for workshop conditions. There should be two or
22 three years of training to prepare them for job situations
23 and prepare them totally for the acceptance of work,
24 rather than the much less formal requirements of the
25 class we have. I certainly believe that 15% of our
26 trainable children will, on attaining the age of 15 and
27 16 and up, be candidates for sheltered workshop conditions,
28 and very few, we believe, will be able to habilitate into
29 a regular work course, but they can be certainly self-
30 supporting by earning some money at a workshop. Again, it
is only time and dollars that prevent us having our work-
shop today.

COMMISSIONER BALTZAN: Mr. Wilby, I see

Mr. Chairman: May I speak a little further
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is only time and dollars that prevent us having our work-

COMMISSIONER JALOWSKI: Yes, sir.



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3 that the average amount to be raised by the Association
4 itself per child per year, by the Association, is \$185.
5 My question is, are you able to meet that?

6 MR. WILBY: We have just met it in the
7 past, but in Winnipeg, a lot of this money is actually
8 spent in Winnipeg. Half the children at the moment
9 that are mentioned in this brief come from Winnipeg or
10 Winnipeg and the suburbs, and we have now reached the
11 point when we don't know whether we can continue the day
12 centre as it is now operated because of this difficulty
13 in raising our share of the money. We have an annual
14 public appeal, and we do get support from service clubs
15 and fraternity organizations, but we are at the point
16 right now -- and the Department of Health knows this --
17 where we may have to curtail some of the services we
18 have at the moment, and there is a waiting list for the
19 services we have. In other words, we can't at the moment
20 provide programs for all the children who are eligible,
21 and if the financial situation does not improve we may
22 even have to curtail what we are doing at the moment, and
23 this is very little. We would like to see pre-school
24 facilities and sheltered workshops in addition to what
25 we have now.

26 COMMISSIONER BALTZAN: My reason for
27 asking that question is that on page 2 under 6(c) you
28 speak of the fact that grants should be made available to
29 assist the provinces. Do I understand that would relieve
30 your position? You are not specifically, if I remember,
making any requests on behalf of your Association for
financial assistance -- or have you?



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4 MR. WILBY: The kind of grant we had in
5 mind here, sir, was similar to the crippled children
6 grants that the Federal Government grants to the provinces.
7 Some such assistance like this would definitely, of course,
8 help the provincial programs.

9 THE CHAIRMAN: Gentlemen, just in the
10 general picture of an overall health service plan, what
11 do you see as the future for a voluntary organization
12 such as yours?

13 MR. WILBY: I would think, sir, that there
14 will always be a considerable amount of work for volun-
15 tary organizations. For example, in Manitoba or in other
16 provinces, if the trainable children were programmed under
17 the public school districts there would always be children
18 who would not fit into that particular program. The
19 matter of the pre-school, I think, with some financial
20 assistance could be run very well by a volunteer organiza-
21 tion. I think there will always be programs. There is
22 the problem of the older retardee in the community who
23 has very few friends. We mention in the brief we are
24 also interested in establishing some kind of community
25 recreational clubs for these older ones, and again this
26 kind of facility will not just affect the children we are
27 concerned with at the moment who are trainable, because
28 these borderline educable retardees, as they get older,
29 have very little to do in the community; they lose their
30 friends. So, I think in that sense there will always be
a need for a volunteer organization.

31 THE CHAIRMAN: Thank you very much, gentle-
32 men. We are indebted to you, and I think we might say
33

MR. ALLAN: The kind of grant we had in

mind here, also, was similar to the crippled children grants that the Federal Government grants to the provinces. Some such assistance like this would definitely, of course, help the provincial programs.

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THE CHAIRMAN: Thank you very much, gentlemen.

We are indebted to you, and I think we must say



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3 this, not only in respect of yourselves but in respect of
4 these various voluntary organizations and volunteer
5 groups who come before us, that we are amazed at the
6 devotion and time and dedication of men such as yourselves,
7 and these various other organizations in these several
8 fields. Thank you very much.

9 MR. WILBY: Thank you, sir.

10 --- Short Recess.
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12 THE CHAIRMAN: Ladies and gentlemen, if
13 you will come to order we will now proceed.
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SUBMISSION OF THE MANITOBA PHARMACEUTICAL
ASSOCIATION

Appearances: Mr. C.T. Oliver
Mr. M.A. Anderson
Dr. J.R. Murray
Mr. J. Litvack
Mr. G.A. Renton

MR. OLIVER: Mr. Chairman and members of the Commission, my name is Oliver. I am a retail pharmacist from Portage la Prairie and immediate past President of the Manitoba Pharmaceutical Association. I have with me today Mr. Anderson, Registrar of the Manitoba Pharmaceutical Association; Dr. J.R. Murray, Director of the School of Pharmacy, University of Manitoba; Mr. J. Litvack, Hospital Pharmacist and President of the Manitoba Chapter of the Canadian Society of Hospital Pharmacists; Mr. G.A. Renton, our Inspector.

I had intended to express a very warm welcome to you to Manitoba, but apparently the weather man has taken a different approach. However, I do welcome you here, and I hope your deliberations here will be most successful.

THE CHAIRMAN: Thank you very much.

MR. OLIVER: It is my privilege to present the brief on behalf of the Manitoba Pharmaceutical Association, and I would like to start with a preamble which will refer to the summary on the first page.

--- EXHIBIT NO. 69: Submission of the Manitoba Pharmaceutical Association.

--- EXHIBIT NO. 69A: Report of the Joint Committee on the Retail Structure of Drug Prices in Manitoba.

SUBMISSION OF THE MANITOBA PHARMACEUTICAL

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Apparatus: Mr. C. I. Oliver
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MR. OLIVER: Mr. Chairman and members of

the Commission, my name is Oliver. I am a retail pharmacist from Portage la Prairie and immediate past President of the Manitoba Pharmaceutical Association. I have with me today Mr. Anderson, Registrar of the Manitoba Pharmaceutical Association; Dr. J. R. Murray, Director of the School of Pharmacy, University of Manitoba; Mr. J. Lillack, Hospital Pharmacist and President of the Manitoba Chapter of the Canadian Society of Hospital Pharmacists; Mr. G. A. Barton, our Inspector.

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THE CHAIRMAN: Thank you very much.

MR. OLIVER: It is my privilege to present to you the report of the Joint Committee on the Retail Pharmacies of Drug Prices in Manitoba, and I would like to start with a preamble which will refer to the summary on the first page.

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4 MR. OLIVER: In accordance with the terms
5 of reference, we have endeavoured to keep our submission
6 short by setting forth the objectives, the legal status
7 of the Association, summary of the Act and powers granted
8 the Association and the provisions contained in the Act
9 for the protection of the public.

10 The Government and objectives of the Asso-
11 ciation and the relationship of the Pharmaceutical Asso-
12 ciation are set forth.

13 We have prepared statistics regarding
14 licensed pharmacies, and licensed pharmacists in the
15 province and the areas served; and their responsibility
16 to the Public and to the Association.

17 We have outlined the distribution of drugs
18 and pharmaceutical services.

19 We have outlined the distribution of drugs
20 and pharmaceutical services.

21 We have outlined participation in
22 different health plans evolved by different government
23 projects. We have projected the role of pharmacy to
24 future health programs.

25 In addition to the recruitment plan set
26 forth in the Appendix II by the University, the Associa-
27 tion carries on an active program of recruitment.

28 The Association, in conjunction with the
29 Faculty members of the University, promotes continuing
30 education for pharmacists.

In 1961 a study of the retail structure of
drug prices in Manitoba was completed by a joint committee
of the Manitoba Pharmaceutical Association and the

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In addition to the report, we have also
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drug prices in Manitoba was completed by a joint committee
of the Manitoba Pharmaceutical Association and the



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3 Government of Manitoba, a copy of which is presented as
4 an exhibit.

5 To assess the provisions made by members
6 for providing dispensing items in accordance with the
7 need of respective areas, a spot check was made on a
8 number of representative pharmacies in the province.

9 The School of Pharmacy has prepared a
10 section on pharmaceutical education and research which is
11 contained in Appendix II.

12 We have submitted a survey of pattern of
13 trends as Appendix III, covering a six-year period,
14 1956-61, showing student enrolment and membership in the
15 Association.

16 Since Section 2 of the summary dealing with
17 conclusion and recommendations is brief and its subsec-
18 tions refer mainly to parts contained in Section 25, may
19 I have your permission to present Section 25 in its
20 entirety, commencing on page 16 of the brief?

21 THE CHAIRMAN: You are free to develop
22 your submission in the way you think most orderly and
23 most acceptable to yourself.
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THE CHAIRMAN: You are free to develop
your submission in the way you think most clearly and



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3 MR. OLIVER: The Association respectfully
4 submits:

5 A. That in the Province of Manitoba the
6 public is well and adequately served by the licensed
7 pharmacists who are well and adequately trained and adhere
8 to the highest traditions of their calling.

9 B. That, subject to one change (ownership
10 of pharmacies), there is no better method of supplying
11 medication or serving the public interest than through
12 the pharmacies (including hospital dispensaries) licensed
13 by it and that the operation of competition amongst phar-
14 macies tends to keep services at a very high level.

15 C. That retail pharmacies are needed in
16 the various communities because:

17 (i) where competition exists there is
18 the creation of a higher standard of health
19 service;

20 (ii) pharmacies are able to give their
21 customers a personal service convenient
22 to their homes;

23 (iii) the patrons, being personally known
24 to the pharmacy, can in most cases secure
25 the drugs from their local pharmacist on
26 credit when necessary;

27 (iv) the pharmacist can maintain a
28 closer check on repeat prescriptions;

29 (v) they are places frequently used in
30 case of accident or sudden illness as a
first aid place;

(vi) they are places that are supervised

MR. OLIVIA: The Association respectfully

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close check on repeat prescriptions;

(v) they are places frequently used in

case of accident or sudden illness as a

first aid place;

(vi) they are places that are supervised



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4 by the Association and must be kept to
5 the Association standard.

6 D. That it views with alarm the steadily
7 increasing number of pharmacies owned and operated by
8 corporations the control of which is in the hands of
9 others than pharmacists.

10 The pharmacist must be in a position where
11 he is free to adhere to the code of ethics and high
12 traditions of his profession, free to discharge to the
13 fullest his professional duties and obligations and free
14 to carry on the business of a pharmacist in accordance
15 with that code.

16 The Association deplores the situation
17 where a pharmacy is controlled by outside capital with
18 the consequent demand for profits and the pressure for
19 earnings that may result in the lowering of the standard
20 of the pharmacy to the detriment of the public and the
21 profession.

22 THE CHAIRMAN: What you are referring to
23 there is the chain stores?

24 MR. OLIVER: Not necessarily all chain
25 stores.

26 THE CHAIRMAN: Well, what are you referring
27 to?

28 MR. OLIVER: Well, sir, we have local
29 corporations here that have been formed to open pharmacies.
30 They have a pharmacist who has been able to get control of
a pharmacy and he operates without any jurisdiction, he is
not even a director of the company and that is what we
are referring to.



by the Association and must be kept in

the Association's hands.

Q. That it views with alarm the steadily

increasing number of pharmacies owned and operated by

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not even a director of the company and that is what we



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3 THE CHAIRMAN: Thank you.

4 MR. OLIVER: E. That wholesale drug houses
5 and distribution depots should be licensed and required:

6 (i) to be staffed with licensed pharma-
7 cists fully familiar with the products
8 carried;

9 (ii) to maintain proper and adequate
10 storage facilities and refrigeration in
11 accordance with the product requirements
12 and governmental regulations.

13 (iii) to be subject to supervision by
14 licensed pharmacists to control the distri-
15 bution of drugs in accordance with all
16 applicable legislation and to see that only
17 fresh stock which has been properly cared
18 for is distributed.

19 F. The Association respectfully points
20 out that if any scheme is considered whereby all persons
21 in Canada are to be supplied with free medication the
22 following factors must be kept in mind:

23 (a) Pharmacists have no control over what
24 is to be furnished; they merely furnish
25 what the prescribers direct.

26 (b) Experience under the Manitoba Medicare
27 plan has shown that the cost of free medica-
28 tion under that plan has far exceeded what
29 was anticipated.

30 (c) Experience in England has shown the
necessity of an increasing number of
restrictions on the medications to be

THE CHAIRMAN: Thank you.

MR. OLIVER: A. That wholesale drug houses

and distribution depots should be licensed and regulated;

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carried;

(5) to maintain proper and adequate

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and Governmental regulations

(6) to be subject to supervision by

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out that if any scheme is considered whereby all persons

in Canada are to be supplied with free medication the

following factors must be kept in mind:

(a) Pharmacists have no control over what

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(c) Experience in England has shown the

necessity of an increasing number of

restrictions on the medication to be



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3 supplied under its plan.

4 (d) Pharmacies would be the only satis-
5 factory outlet for the supply of medication
6 to the public.

7 (e) Any such scheme would involve the
8 establishment of a schedule of charges
9 which should from time to time be adjusted
10 according to the cost of living index.

11 (f) Under any such scheme the pharmacist
12 should be free to practise his profession
13 without any limitation except as may be
14 agreed upon by the Association.

15 G. The Association draws to the attention
16 of the Commission the increased expectancy of life.

17 Ever-increasing numbers of prescriptions are for persons
18 over 70 years of age who require continuous medication.

19 Any health plan including the supply of free medication
20 must allow for a continuous rise in the cost of supplying
21 such medication corresponding with the increase in the
22 number of persons over 70.

23 H. The Manitoba Pharmaceutical Association
24 recommends the following staffing patterns for pharmacists
25 in hospitals:

26 (a) Hospitals with 20 to 50 beds require
27 the services of a pharmacist on a part-
28 time basis.

29 (b) Hospitals of 50 beds or more require
30 the full-time services of a hospital phar-
macist.

The value of a pharmacist in the hospital



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(d) Pharmacies would be the only entities

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(e) Any such scheme would involve the

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Ever-increasing numbers of prescriptions are for persons

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recommends the following staffing patterns for pharmacists

in hospitals:

(a) Hospitals with 10 to 50 beds require

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time basis.

(b) Hospitals of 50 beds or more require

the full-time services of a pharmacist during

The value of a pharmacist in the hospital



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4 has been proven. From an economic viewpoint the hospital
5 pharmacist can effect savings by establishment of hospital
6 formularies, efficient purchasing policies and by the
7 establishment of a manufacturing program for certain
8 standard formulations.

9 With the advent of "Controlled Drug"
10 legislation and narcotic regulations a pharmacist is
11 required in order to establish certain adequate control
12 systems within the hospital. It should be emphasized
13 that the duties of the hospital pharmacy department
14 should be the dispensing of medication only to "hospital
15 in-patients" and bona fide "out-patients".

16 The Manitoba Hospital Survey Board reports
17 non-federal, public and private hospitals including
18 chronic treatment beds in Winnipeg Municipal Hospitals
19 (441) as being 5,219. Of this number full time pharma-
20 ceutical services are provided for 3,228 beds and part
21 time services for 248 beds. Thus leaving 1,743 beds
22 where pharmaceutical services are being performed by
23 persons other than qualified pharmacists.

24 I think this comes to possibly 33%.

25 I. The Association points out that,
26 while some areas of the province, due to sparse popula-
27 tion and lack of accessibility, are not as yet served by
28 local pharmacies, these are largely looked after by the
29 Health Department or by physicians who carry the bare
30 essentials and give this service in addition to their
31 medical practice.

32 J. The Association endorses the recommen-
33 dations set forth in paragraphs "E" and "F" of number 3
34



pharmacist can effect savings by establishment of hospital
formulas, efficient purchasing policies and by the
establishment of a manufacturing program for certain
standard formulations.

With the advent of "Controlled Drugs"
legislation and narcotic regulations a pharmacist is
required in order to establish certain separate control
systems within the hospital. It should be emphasized
that the duties of the hospital pharmacy department
should be the dispensing of medication only to "hospital
in-patients" and bona fide "out-patients".

The Manitoba Hospital Survey Board reports
non-federal, public and private hospitals including
chronic treatment beds in Winnipeg Mental Hospitals
(441) as being 5,110. Of this number full time psycho-
neurological services are provided for 1,128 beds and part
time services for 148 beds. Thus leaving 1,713 beds
where pharmacological services are being performed by
persons other than qualified pharmacists.

I think this leaves no doubt that
1. The Association points out that
while some areas of the province, due to sparse popula-
tion and lack of accessibility, are not yet served by
local pharmacies, these are largely looked after by the
Health Department or by physicians who carry the basic
essentials and give this service in addition to their
medical practice.

2. The Association stresses the need for
stations not located in paragraphs "5" and "7" of number 1



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4 of the section of this submission contained in Appendix
5 II.

6 At this point I would like to read
7 Section E.

8 E. It is recommended that a manpower
9 survey be conducted to assist in planning for the future.

10 F. It is recommended that federal aid to
11 universities be increased for the following purposes:

12 (1) To attract to the faculty academi-
13 cians of high calibre; provision of higher
14 salaries for qualified teachers and
15 researchers will help to combat the compe-
16 tition of industry and of foreign univer-
17 sities.

18 (2) To provide capital funds to assist
19 the university in its building requirements,
20 particularly in the expansion of the
21 professional and scientific areas, in
22 addition to maintaining its support of
23 the social sciences and humanities.

24 (3) To expedite the development of
25 research. This may be done by the provi-
26 sion of (a) grants for equipment, (b)
27 scholarships and fellowships for graduate
28 students, and (c) post-doctoral fellow-
29 ships.

30 K. The Association requests the privilege
of making a further submission should it deem a further
submission would be of value and assistance to the
Commission or the Commission requested a further submission.

II

Section 5.



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3 THE CHAIRMAN: There will be no difficulty
4 on that score at any of the subsequent hearings.

5 MR. OLIVER: Thank you.

6 L. The Association concurs in the preli-
7 minary statement of The Canadian Pharmaceutical Associa-
8 tion and makes its submission to acquaint the Commission
9 with the practice of pharmacy in Manitoba and to acquaint
10 the Commission with problems peculiar to Manitoba and
11 the Association's information, views and recommendations.

12 THE CHAIRMAN: Mr. Oliver, do either your-
13 self or your associates wish to add anything further?

14 MR. OLIVER: I do not think so. I think
15 we are prepared to answer any questions that may be
16 developed from the Commission.

17 THE CHAIRMAN: On page 17 when you are
18 reading about the ownership and so forth of pharmacies,
19 what is the view of your Association in regard to the
20 pharmacies in these medical clinics?

21 MR. OLIVER: That is one of our problems
22 that concerns us. We feel that a medical man practising
23 his profession and in some cases a medical group have
24 formed a corporation and operate a pharmacy. The pharma-
25 cist has no share in this business other than being
26 employed there. We feel this is unethical for a medical
27 man to not only practise his profession but, in many
28 cases, insist that his patients go to that particular
29 pharmacy in his own operation. It prevents a patient
30 having free choice of pharmacy services. We have some
evidence here we would like to present to you if you care
to listen to it by our inspector in which coded

THE CHAIRMAN: There will be no difficulty

on that score at any of the subsequent hearings.

MR. OLIVER: Thank you.

5. The Association concurs in the preliminary statement of the Canadian Pharmaceutical Association and makes its submission to assist the Commission with the practice of pharmacy in Manitoba and to assist the Commission with problems peculiar to Manitoba and

THE CHAIRMAN: Mr. Oliver, do either you

self or your associates wish to add anything further?

MR. OLIVER: I do not think so. I think

we are prepared to answer any questions that may be

developed from the Commission.

THE CHAIRMAN: On page 1, when you are

reading about the ownership and so forth of pharmacies,

what is the view of your Association in regard to the

pharmacies in these medical clinics?

MR. OLIVER: That is one of our problems

that concerns us. We feel that a medical man practicing

his profession and in some cases a medical group have

formed a corporation and operate a pharmacy. The pharmacy

list has no share in this business other than being

employed there. We feel this is unethical for a medical

man to not only practice his profession but, in many

cases, insist that his patients go to that particular

pharmacy in his own operation. It prevents a patient

having free choice of pharmacy services. We have some

evidence here we would like to present to you if you want

to listen to it by our inspection in which cases



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3 prescriptions are sometimes used.

4 THE CHAIRMAN: Well, it is in your hands.

5 MR. RENTON: Members of the Commission: I
6 was engaged as an Inspector by the Association and in
7 going about my duties I encountered prescriptions that
8 no pharmacist or medical man was able to decipher for me.
9 The crux of it was I was out at a place called Altona
10 and I asked the pharmacist if he was having any problems.
11 This man said "I have one here" and he produced some
12 capsules. He said "What are these?" I said, "I don't
13 know".

14 Coming back from Altona I stopped at the
15 drugstore at Morris and in completing my business there
16 I asked this pharmacist the same question. He said, "Yes,
17 last week I had difficulty with a prescription". I got
18 all the particulars. I came back into the city and made
19 a survey of some 20 drugstores and I found the same condi-
20 tion existed at each drugstore. At that time all the
21 prescriptions involved were prefixed by a code word which
22 spelled CLINDEX. After a lot of trouble and inquiry we
23 found out that this code word was registered under a
24 trademark at Ottawa and was described as preparations for
25 vitamin deficiencies, a preparation for relief of anaemia,
26 a dietary supplement for pre-natal care, a treatment for
27 iron deficiencies, a preparation for relief of alkalosis
28 and dyspepsia, a preparation for relief of acid indiges-
29 tion, a laxative preparation, a capsule for pain relief,
30 a liniment, a suppository for haemorrhoid relief, a
medicinal powder for feminine hygiene. Now, anyone
getting a prescription of that nature from one pharmacist,



THE CHAIRMAN: Well, it is in your hands.

MR. KATHOLAN: Members of the Commission: I

was engaged as an Inspector by the Association and in
going about my duties I encountered prescriptions that
no pharmacist or medical man was able to decipher for me.
The only one of it was I was out at a place called Alton
and I asked the pharmacist if he was having any problems.
[REDACTED]
capsules. He said "What are these?" I said, "I don't
know".

Coming back from Alton I stopped at the
drugstore at Morris and in consulting my business there
I asked this pharmacist the same question. He said, "Yes,
last week I had difficulty with a prescription. I got
all the particulars. I came back into the city and made
a survey of some 70 drugstores, and I found the same condi-
tion existed at each drugstore. At that time of the
[REDACTED]
[REDACTED]
[REDACTED]
found out that this code word was repeated under a
trademark at Alton and was described as a preparation for
vitamin deficiencies, a preparation for relief of anemia,
a dietary supplement, or general care, a preparation for
from deficiency of a preparation for relief of blood impurities
and dyspepsia, a preparation for relief of acid indigestion,
tion, a laxative preparation, a capsule for pain relief,
calmness, a preparation for rheumatic relief, a
medical powder for feminine hygiene. Now, having
getting a prescription of this nature from our pharmacist,



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3 this is what happened: this particular prescription was
4 repeated four times and it incurred a special trip made
5 downtown each time and sometimes delay in delivery to a
6 customer. With this case at Altona and Morris there
7 was an aged pair of grandparents in midwinter and they
8 were occasioned a trip of approximately 92 miles and a
9 delay of five days before they got the prescription
10 filled. I have the code here and the incorporation of
11 the code and those particular capsules were named Clindex
12 capsules. They were available in any drugstore under
13 their trade name of Adec. I have many prescriptions here
14 where this condition is involved and I could go out and
15 get hundreds more. Now, the situation still persists.
16 The Association has tried to get amendments to the legis-
17 lation in order to control that but they have not been
18 successful so far. Now, when you take those old people
19 travelling 90-odd miles in midwinter to get such a
20 simple preparation there is something radically wrong.
21 I think that is about all.

22 COMMISSIONER BALTZAN: Was that a prescrip-
23 tion, a doctor's prescription you are referring to?

24 MR. RENTON: At Altona the old couple
25 brought in a bottle with a prescription number on it and
26 he asked the chap if he would fill it and was told he
27 could get it if he 'phoned up this company store which
28 he did and they told him it was one of their own prepara-
29 tions but they would ship it out to him less 30%.

30 COMMISSIONER BALTZAN: My question was,
was that a doctor's prescription or a thing bought over
the counter?



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3 MR. RENTON: A doctor's prescription
4 reading "Clindex capsules".

5 COMMISSIONER BALTZAN: And the contents
6 of that prescription would not be known to the doctor or
7 would it?

8 MR. RENTON: Yes, we have the code of
9 that particular corporation.

10 COMMISSIONER BALTZAN: Code?

11 MR. RENTON: Yes.

12 COMMISSIONER BALTZAN: But the elements
13 of that prescription; would it be known to anybody else
14 but the company?

15 MR. RENTON: It was available in other
16 drugstores.

17 MR. OLIVER: I think I can clarify that
18 by saying that the doctor ordered this prescription under
19 Clindex and it was sent down to the pharmacy which he had
20 an interest in and the pharmacist who worked for him was
21 the only one who knew or was able to translate that
22 prescription.

23 COMMISSIONER BALTZAN: Was the information
24 concerning the elements in the prescription available and
25 known to the doctor who prescribed it?

26 MR. OLIVER: Oh, very definitely. He
27 prescribed it as Clindex capsules.

28 COMMISSIONER BALTZAN: Yes, the name, but
29 did he know what that name covered?

30 MR. OLIVER: I would think he would.

COMMISSIONER BALTZAN: Is the information
concerning these ingredients available? I hear it spoken



COMMISSIONER: Yes, the contents

of that prescription would not be known to the doctor or
would it?

MR. KILICK: Yes, we have the code of

that particular corporation.

COMMISSIONER: Yes, today?

COMMISSIONER: Yes, but the elements

of that prescription; would it be known to anybody else
but the company?

MR. KILICK: It was available in every

pharmacy.

MR. OLIVER: I think I can clearly find

by saying that the doctor ordered this prescription under
Gibber and it was sent down to the pharmacy which he had
an interest in and the pharmacist who worked for him was
the only one who knew or was able to furnish that

COMMISSIONER: Yes, the information

concerning the elements in the prescription available and
known to the doctor who prescribed it?

MR. OLIVER: Oh, very definitely, yes.

COMMISSIONER: Yes, the name, but

did he know what that name covered?

MR. OLIVER: I would think he would.

COMMISSIONER: Yes, is the information

concerning these ingredients available? I mean is it a



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3 of by code name but suppose somebody knew this was the
4 kind of thing that a neighbour had and he would like to
5 have it too, the physician that would prescribe that
6 would want to know what is in the prescription?

7 MR. OLIVER: These were patients of this
8 particular doctor, this was a patient of this particular
9 doctor and he prescribed this medication as Clindex.

10 COMMISSIONER BALTZAN: I agree to that.

11 MR. OLIVER: And it went down to the
12 pharmacy in his building to be filled and it was filled
13 and it went out to Altona and when they want it repeated
14 they went to the drugstore there.

15 COMMISSIONER BALTZAN: I could not get it?

16 MR. OLIVER: The druggist 'phoned into
17 Winnipeg to get a copy of the prescription but in Altona
18 the druggist did not know what it was.

19 COMMISSIONER BALTZAN: Did the doctor know?

20 MR. OLIVER: The doctor who prescribed it
21 or the doctor in Altona?

22 COMMISSIONER BALTZAN: The doctor who
23 prescribed it.

24 MR. OLIVER: Very definitely.

25 COMMISSIONER McCUTCHEON: He controlled
26 the pharmacy?

27 MR. OLIVER: Yes.

28 MR. RENTON: It would possibly help if I
29 passed a number of these through the Commission with a
30 card index showing the character ---

THE CHAIRMAN: I think your explanation
takes us as far as any perusal of any prescriptions.

of by code name but suppose somebody knew this was the
kind of thing that a physician had and he would like to
have it too, the physician that would prescribe that
would want to know what is in the prescription?

COMMISSIONER: I agree to that.

MR. OLIVER: And it went down to the
pharmacy in his building to be filled and it was filled
and it went out to Adams and when they want it reported
they went to the drugstore there.

COMMISSIONER: I could not get it?

Witness to get a copy of the prescription and in Adams
the druggist did not know what it was.

MR. OLIVER: The doctor who prescribed it

on the doctor in Adams?

COMMISSIONER: The doctor who

prescribed it.

COMMISSIONER: He controlled

MR. OLIVER: It would possibly help if I

passed a number of these through the Commission with a

card index showing the character --

MR. CHAIRMAN: I think your suggestion



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4 MR. RENTON: Now, further to that, I have
5 a copy of the particular trademark registration at Ottawa.
6 This is registered in the name of five individuals,
7 medical men. The same year we have an application for
8 a shop licence for this particular pharmacy and it shows
9 the signing officers as two women; the medical people
10 are male.

11 THE CHAIRMAN: If you wish to file that
12 we will receive it, and it will be Exhibit 69B.

13 --- EXHIBIT NO. 69B: Registration of trademark.
14 --- EXHIBIT NO. 69C: Application for shop licence.
15 --- EXHIBIT NO. 69D: Application for shop licence.
16 --- EXHIBIT NO. 69E: Prescriptions and index cards.

17 COMMISSIONER BALTZAN: Are the component
18 parts enclosed therein?

19 MR. RENTON: Yes.

20 COMMISSIONER STRACHAN: Has the average
21 druggist any means of finding out what that product is?

22 MR. OLIVER: No, he has not, unless the
23 pharmacist is prepared to tell him or the prescribing
24 physician is prepared to tell him. Clindex is not a
25 common trademark, it is not known to any other group.

26 MR. RENTON: Mr. Chairman, the point I
27 really want to make; last week I ran into another such
28 prescription from another company and if this trend
29 continues all we are doing is confounding the teachings
30 of the medical and pharmacy professions. When we recall
that we are subsidizing the universities, it is an awkward



... a copy of the particular trademark registration at Ottawa.
This is registered in the name of five individuals.
medical men. The same year we have an application for
a shop license for this particular pharmacy and it shows
the signing officers as two women; the medical people
THE CHAIRMAN: If you wish to file that
we will receive it, and it will be Exhibit 655.

- EXHIBIT NO. 658: Registration of trademark.
- EXHIBIT NO. 659: Application for shop license.
- EXHIBIT NO. 660: Application for shop license.
- EXHIBIT NO. 661: Prescriptions and index cards.

parts enclosed therein?

COMMISSIONER: Was the average
druggist any means of thinking out what that product is?
MR. OLIVER: No, he has not, unless the
pharmacist is prepared to tell him on the prescription.

common trademark, it is not known to any other group.
MR. REYNOLDS: Mr. Chairman, can you not
really want to make; I am sure I am into another such
prescription from another company and it is this trend.

... from which we receive



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3 situation at the best.

4 THE CHAIRMAN: What remedy do you suggest?

5 MR. RENTON: The only remedy I suggest
6 would be that these small companies whose stock is not
7 listed on the stock market have some prohibition placed
8 against their involvements. They are increasing all the
9 time.

10 THE CHAIRMAN: These are pharmacy corpora-
11 tions?

12 MR. OLIVER: Yes, sir.

13 MR. RENTON: Yes. It boils down to this:
14 three individuals could be released from the penitentiary
15 today, they could hire a pharmacist, form a company and
16 obtain a pharmacy licence.

17 COMMISSIONER McCUTCHEON: Is that what you
18 are really objecting to?

19 MR. RENTON: It is the practice revolving
20 through these companies.

21 COMMISSIONER McCUTCHEON: What you are
22 really objecting to is medical men controlling a pharmacy
23 with the result that prescriptions are directed either
24 by code or otherwise?

25 MR. OLIVER: They are channelled.

26 COMMISSIONER McCUTCHEON: Channelled to
27 their own firm?

28 MR. OLIVER: Yes.

29 COMMISSIONER McCUTCHEON: Has the matter
30 been discussed with the College of Physicians and Surgeons?

MR. OLIVER: We are presenting it before
them.



THE CHAIRMAN: What remedy do you suggest?

MR. REED: The only remedy I suggest

would be that these small companies whose stock is not

owned by the public should be taken over by the public.

against their investments. They are interested in the

time.

tion?

MR. OLIVER: Yes, sir.

three individuals could be released from the penitentiary

today, they could hire a pharmacist, form a company and

obtain a pharmacy license.

COMMISSIONER McOUTCHEN: Is that what you

are really objecting to?

MR. REED: It is the practice revolving

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COMMISSIONER McOUTCHEN: Has the matter

been discussed with the College of Physicians and Surgeons?

MR. OLIVER: We are presenting it before



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3 COMMISSIONER McCUTCHEON: What is the
4 result?

5 MR. RENTON: It is still continuing.

6 COMMISSIONER BALTZAN: Where does the
7 Drug and Food Act come in in relation to these prescrip-
8 tions compounded and sold under a trade name?

9 MR. RENTON: Well, I haven't the answer to
10 that.

11 MR. OLIVER: Before we answer Dr. Baltzan's
12 question, we would like to reserve and answer later on.

13 COMMISSIONER VAN WART: In broad terms,
14 you are in favour of generic names of drugs, rather than
15 brand names?

16 MR. OLIVER: Well, this gets into quite
17 a discussion.

18 THE CHAIRMAN: Yes, that is another subject.

19 MR. OLIVER: We are not in favour of it,
20 did you say?

21 COMMISSIONER VAN WART: You are in favour
22 of generic, rather than brand names?

23 MR. OLIVER: Well, generic names, that
24 broadens the field.

25 COMMISSIONER VAN WART: The point is they
26 cannot order a drug under a code if they must order it
27 under a generic name.

28 MR. OLIVER: Or a trade name. What we do
29 object to is secret coding.

30 THE CHAIRMAN: Which has the effect of
directing the purchaser to a specific store?

MR. OLIVER: That is right.



COMMISSIONER MONTGOMERY: What is the

MR. REMON: It is still continuing.

COMMISSIONER MONTGOMERY: Where does the

Drug and Food Act come in in relation to these prescrip-

tions compounded and sold under a trade name?

MR. REMON: Well, I haven't the answer to

that.

MR. OLIVER: Before we answer Dr. Remon's

question, we would like to reserve and answer later on.

COMMISSIONER VAN WART: In broad terms,

you are in favour of generic names of drugs, rather than

brand names?

MR. OLIVER: Well, this goes into quite

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THE CHAIRMAN: Yes, that is another subject.

MR. OLIVER: We are not in favour of it.

did you say?

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of generic, rather than brand names?

MR. OLIVER: Well, generic names, that

broadens the field.

COMMISSIONER VAN WART: The point is they

under a generic name.

MR. OLIVER: Is a trade name. What we do

THE CHAIRMAN: Which was the object of

directing the purchaser to a specific store?

MR. OLIVER: That is right.



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4 COMMISSIONER McCUTCHEON: You don't like
5 vertical integration in the medical and pharmaceutical
6 field?

7 MR. OLIVER: That is true.

8 MR. RENTON: No, the people in the country
9 when they are really sick, they think they have to come
10 to the city to see a doctor, and when they come to see
11 the doctor they expect fair treatment, and for a man
12 and an old lady to travel over 90 miles to get such a
13 simple formula, the thing is a farce.

14 THE CHAIRMAN: Page 17, D, where you say:
15 "That it views with alarm the steadily increasing number
16 of pharmacies owned and operated by corporations ---".
17 These are the type of corporations you are talking about
18 then, and not, say, such as Tamblyn's or ---?

19 MR. RENTON: We have no trouble with ---

20 THE CHAIRMAN: No, I am just using that
21 name as one of the nationally-owned groups which have
22 stores in various provinces.

23 MR. RENTON: Correct.

24 MR. OLIVER: Mr. Chairman, we could prepare
25 a list of the number of limited companies we have that are
26 non-pharmacy represented, and send it to you if you so
27 desire.

28 THE CHAIRMAN: That would be desirable,
29 if you will. Does this apply only to the Province of
30 Manitoba, or is it Canada-wide in its application?

MR. OLIVER: I believe it is more prevalent
in Manitoba than in any other province. I understand New
Brunswick do have the same problem, or one similar.

CONSIDERING THE POSITION: YOU DON'T LIKE

THE POSITION: YOU DON'T LIKE

MR. OLIVER: That is true.

MR. KATHW: Yes, the people in the country

when they are really sick, they think they have to come

to the city to see a doctor, and when they come to see

the doctor they expect fair treatment, and for a man

and an old lady to travel over 50 miles to get such a

simple formula, the thing is a farce

THE CHAIRMAN: Page 14, D. Where you say:

"That is views with which the steadily increasing number

of pharmacies owned and operated by corporations --"

These are the type of corporations you are talking about

then, and not, say, such as Parity's or --?

MR. KATHW: We have no trouble with --

THE CHAIRMAN: No, I am just asking that

name as one of the nationally-owned groups which have

stores in various provinces.

MR. KATHW: Correct.

MR. OLIVER: Now, Chairman, we can't prepare

a list of the number of limited companies we have that are

non-pharmacy represented, and send it to you if you so

desire.

THE CHAIRMAN: That would be desirable.

if you will. Does this apply only to the Province of

Ontario, or does it apply to the whole of Canada?

MR. OLIVER: It applies to the whole of Canada.

THE CHAIRMAN: All right, we will accept that.



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4 COMMISSIONER STRACHAN: Is there no law
against secret coding?

5 MR. OLIVER: Not to my knowledge sir.

6 MR. ANDERSON: Not to my knowledge.

7 COMMISSIONER STRACHAN: Does the College
8 of Physicians and Surgeons view this as an ethical
9 practice?

10 MR. OLIVER: That is something I couldn't
11 answer.

12 COMMISSIONER STRACHAN: What has been
13 your reception by them? How have they received you?

14 MR. OLIVER: We have never got too far
with them sir.

15 MR. RENTON: The condition continues, as
16 recently as last week.

17 THE CHAIRMAN: Well now gentlemen, you
18 have an organized body. Can such a corporation exist
without an employed, qualified pharmacist?

19 MR. OLIVER: No sir.

20 THE CHAIRMAN: Would you have any control
21 over employment over a person offering his services to
22 such a corporation as being an ethical thing for a
23 registered pharmacist to do?

24 MR. OLIVER: No sir. At least we have
25 never tried to apply it. I doubt if we could get very
far with it.

26 MR. RENTON: Human nature being as it is,
27 there must be some rigid application of the law to such
28 a condition.

29 THE CHAIRMAN: Does your Association regard
30

MR. OLIVER: Not to my knowledge sir.

MR. ANDERSON: Not to my knowledge.

COMMISSIONER STRACHAN: Does the College

of Physicians and Surgeons view this as an ethical

practice?

MR. OLIVER: That is something I couldn't

answer.

COMMISSIONER STRACHAN: What has been

your reception by them? How have they received you?

MR. OLIVER: We have never got too far

THE CHAIRMAN: Well now gentlemen, you

have an organized body. Can such a corporation exist

without an employed, qualified pharmacist?

MR. OLIVER: No sir.

THE CHAIRMAN: Would you have any control

over employment over a person offering his services to

such a corporation as being an ethical thing for a

registered pharmacist to do?

MR. OLIVER: No sir. At least we have

never tried to apply it. I doubt if we could get very

far with it.

MR. BRYTON: Human nature being as it is,

there must be some slight application of the law to bring

a condition.

THE CHAIRMAN: Does your Association regard



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3 the taking of employment by a registered pharmacist in
4 one of these corporations that you have such a view of
5 as being unprofessional?

6 MR. RENTON: No. Proof is a difficult
7 thing.

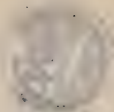
8 THE CHAIRMAN: It is not a matter of proof,
9 but I mean to say, do you regard it as being the right
10 or not the right thing for a registered pharmacist to
11 take employment with a corporation that you think should
12 not exist?

13 MR. ANDERSON: Mr. Chairman, this presents
14 a problem to the Association in that under the Provincial
15 Pharmaceutical Act, a corporation is entitled to offer a
16 pharmaceutic, provided they employ a pharmacist and place
17 the pharmacist in charge of the operation. We are duty-
18 bound then if they comply with this, to issue a licence.
19 It is very difficult to tell one of our members not to
20 work for this corporation. Then this is the type of
21 thing that develops out of employment, and our member is
22 at, shall we say, the mercy of his employer. Herein
23 lies the tale, it is his bread and butter, and if he does
24 not wish to conform, the corporation could very well
25 find another member of the Association who would be
26 willing to be employed and comply with the dictates of
27 the directors and management.

28 THE CHAIRMAN: So it is a matter of economic
29 necessity that your members take employment?

30 MR. ANDERSON: Yes.

MR. RENTON: The corporation or the company,
they have the full control, including the keys to the



the taking of employment of a registered pharmacist in
one of these corporations that you have such a view of
as being impractical?

MR. RICHMOND: No, I think it is a difficult

thing.

THE CHAIRMAN: It is not a matter of fact,

but I mean to say, do you regard it as being the right
or not the right thing for a registered pharmacist to
take employment with a corporation that you think should
not exist?

MR. ALDERSON: Mr. Chairman, this presents

a problem to the Association in that under the Industrial
Pharmaceutical Act, a corporation is entitled to obtain a
pharmaceutical, provided they employ a pharmacist and place
the pharmacist in charge of the operation. We are not
bound then if they comply with this, to issue a license.
It is very difficult to tell one of our members not to
work for this corporation. Then this is the type of

thing that develops out of employment, and our member is
at, shall we say, the mercy of his employer. I think
lies the tale, it is his greed and power, and if we were
not wish to control, the corporation could very well
find another member of the Association who would be
willing to be employed and comply with the dictates of

the directors and management.

THE CHAIRMAN: So it is a matter of choice

and necessity that your member is the employer?

MR. ALDERSON: Yes.

MR. RICHMOND: The corporation or the company?

they have the full control, including the right to



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3 premises and the keys to the narcotics and all the drugs.

4 THE CHAIRMAN: Well then, is your quarrel
5 with the legislature and the legislation?

6 MR. ANDERSON: I may say there are other
7 than medical corporations coming in the scene. This is
8 what alarming us. Also these small corporations with no
9 pharmacists. We did endeavour, Mr. Chairman, in 1955,
10 to have our active members requesting the majority stock
11 of any corporation operating a pharmacy to be under the
12 control of qualified pharmacists. Our provincial legis-
13 lature, in their wisdom, didn't deem fit to grant this
14 privilege.

15 THE CHAIRMAN: Well, a store, an organization
16 say such as Eaton's, the retail pharmacy is part of their
17 operation in Winnipeg?

18 MR. ANDERSON: Yes.

19 COMMISSIONER FIRESTONE: Are the objections
20 which you are raising to fly-by-night corporations?

21 MR. ANDERSON: Not necessarily so, some
22 remain in business quite permanently.

23 COMMISSIONER FIRESTONE: But you maintain
24 that they are not following appropriate standards
25 acceptable to your Association?

26 MR. ANDERSON: That is true in certain
27 cases.

28 COMMISSIONER FIRESTONE: And you would
29 like them to follow certain standards?

30 MR. ANDERSON: We feel in the interests of
the public and the profession that the standards should
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which you are relating to fifty-eight corporations?

MR. ANDERSON: Not necessarily so, some

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COMMISSIONER FLETCHER: But you maintain

that they are not following appropriate standards

acceptable to your Association?

MR. ANDERSON: That is true in detail.

COMMISSIONER FLETCHER: And you would

like them to follow certain standards?



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4 COMMISSIONER FIRESTONE: And you feel that
5 in order to achieve those standards, legislation has to
6 be introduced to enforce such standards?

7 MR. ANDERSON: We believe this would be a
8 great help sir. This would then place the majority of
9 your shareholders as qualified pharmacists under the
10 disciplinary power of the Association.

11 COMMISSIONER FIRESTONE: Have you any
12 specific proposals to submit to this Commission as to
13 what kind of legislation you would consider appropriate
14 to deal with the problem, and if you do not have it at
15 the moment, could you give consideration to it and let
16 the Commission know of your proposals at a later date?

17 MR. ANDERSON: We would be very happy to
18 conform with that request.

19 COMMISSIONER McCUTCHEON: We would be
20 interested to know, in any suggestions you make along
21 those lines, to know what you would do with the share-
22 holders of Tamblyn's, and other large and reputable
23 organizations that do run pharmacies. I understood that
24 your complaint was against having a pharmacy controlled
25 by people who could thereby direct business to it, and
26 thereby take that business out of the normal competition
27 stream, rather than against a perfectly reputable corpora-
28 tion that is operating a pharmacy in competition with you,
29 just as you sell many, many goods in competition with
30 people who are in different types of business. I see
that 23.9% of your business is prescription drugs. The
fact is that drugstores are getting into a great variety
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3 thing. Are you objecting to that, or is it merely when
4 you take it out of the stream of competition to having
5 the control of the business able to direct the business?

6 MR. ANDERSON: That is one reason sir.

7 COMMISSIONER McCUTCHEON: Then what is the
8 reason that you object to? We have used the name, and
9 just as an example, why do you object to Tamblyn's?

10 MR. ANDERSON: If I may say this, we have
11 not had any problem with a corporation of that type.

12 COMMISSIONER McCUTCHEON: What are the
13 standards that, aside from the element of non-competition
14 and tying the recipient of the prescription to a parti-
15 cular store, what are the other difficulties that you
16 have had with these corporations?

17 MR. ANDERSON: Some difficulty in observing
18 supervision, proper and adequate supervision, and possibly
19 as you are aware today we are having increasing joint
20 control in legislation, and when you have people abso-
21 lutely responsible for the operation of a business, who
22 are not conversant with all these regulations, who are
23 in possession of the means of access to the premises at
24 any time, this places our member in a very embarrassing
25 position with respect to his responsibility.

26 THE CHAIRMAN: Following from there, you
27 say this matter of the owner not knowing the regulations,
28 say now one of your members will die, and his widow is
29 going to carry on the operation of the drugstore with
30 the aid of an employed pharmacist. Are you going to
take the same view there? She does not know anything
about the drug business, or drugs, she is not a pharmacist.

ning. Are you objecting to that, or is it merely when you take it out of the stream of competition to having the control of the business and to direct the business? That is one reason also.

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4 MR. ANDERSON: I will say this. At the
5 request of the Law Amendments of the Provincial Legisla-
6 ture in 1955, this clause or provision was put into our
7 Act, at the request of the Legislature.

8 THE CHAIRMAN: What law?

9 MR. ANDERSON: That the widow may continue
10 to own and operate a pharmacy. The widow of a pharmacist.

11 THE CHAIRMAN: Yes, but what is essentially
12 the difference between that situation and the corporation?

13 MR. OLIVER: Most times, sir, it gives them
14 a stop-gap to arrange the estate and settle it, and in
15 most cases that is what happens. The widow carries on
16 for a time, and then she sells out the business to some-
17 body else.

18 MR. RENTON: Possibly with respect to these
19 small corporations, this case would be of interest. A
20 lady went to a company pharmacy. She went to the doctor
21 in that particular clinic group. She got a prescription
22 for Meticorten. It was the weekend, and she said she
23 was quite a piece from her neighbourhood pharmacy, would
24 the doctor tell his pharmacist to give her sufficient to
25 carry over. She went to her local pharmacy at the
26 beginning of the week with the prescription. She had a
27 sample of the medication she got from this company-owned
28 pharmacy. She asked the pharmacist to fill it. He
29 recognized this sample that she had brought in as not
30 being the same product that was mentioned in the prescrip-
tion, so he 'phoned the pharmacist at this company phar-
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3 the company application, and I found that the pharmacist
4 was only an employee of this company. The lady told me,
5 she said I asked the doctor if he had any interest in the
6 pharmacy. He told me he had none. I showed her the
7 application. I said there's the proof that he has, so
8 I said what did he tell you when you explained this
9 substitution? She said, you go in and give him hell.
Now, that is the position.

10 THE CHAIRMAN: Go in and give him hell.

11 COMMISSIONER BALTZAN: The nicest thing
12 she could have said.

13 THE CHAIRMAN: Now to come to another
14 phase. Page 20, where you are saying about requiring
15 in your judgment that there should be more hospital
16 pharmacists, and you come up with the figure of 1,743
17 beds where pharmaceutical services are being performed
18 by persons other than qualified pharmacists. Have you
19 got the breakdown of that? Does that come down under the
50-bed units? Is this a composite of many small units?

20 MR. LITVACK: In the main, it is. All
21 the city hospitals employ pharmacists. The breakdown
22 would be 13 hospitals employ pharmacists out of a total
23 of 71 in the province. The municipal hospital concerns
24 one particular institution within the city.

25 THE CHAIRMAN: I will read from Page 20:
26 "The Manitoba Hospital Survey Board reports non-federal,
27 public and private hospitals including chronic treatment
28 beds in Winnipeg municipal hospitals as being 5,219".
Now, that is for the whole province, is it?

29 MR. LITVACK: That is right.
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4 THE CHAIRMAN: In the whole province then,
5 there are 1,743 beds where pharmaceutical services are
6 being performed by persons other than qualified pharma-
cists?

7 MR. LITVACK: That is correct. This is
8 mainly small institutions, in most cases under 50 beds,
9 and this is where the Association has pointed out that
10 part-time pharmacists in hospitals of 20 or 50 beds.
11 This has been with the co-operation of the Manitoba
12 Hospital Services Plan, a part-time pharmacist was
13 hired in Morris, Manitoba, a small community 45 miles
14 south of Winnipeg, hired to work 50% of his time within
15 the hospital, and 50% of his time in the retail pharmacy
16 in that community. I was speaking with him last week,
17 and he has increased his service to Emerson. He puts
18 in approximately 70% of his time within the hospital
19 now, and only 30% within the retail pharmacy, and this
is the type of experiment, it was an experiment actually.

20 THE CHAIRMAN: And it is working satis-
factorily?

21 MR. LITVACK: Very satisfactorily, yes,
22 and as a matter of fact he provided figures, which I
23 thought were quite interesting as well, and before the
24 hiring of this pharmacist in Morris itself, the Super-
25 visor of Nursing at the time spent 70% of her time in
26 drug purposes and in pharmaceutical dispensing. At the
27 present time she devotes only approximately 15% of her
28 time to these duties, and according to the administrator
29 of this hospital, this represents a saving of approxi-
30 mately \$264 a month for the Supervisor of Nursing, and



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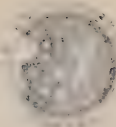
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4 MR. LITVACK: Correct. This is the type
5 of thing we would recommend, and I think this will come
6 about eventually. I think the problem had been to
7 obtain pharmacists for these small institutions. I
8 think several smaller ones would like to obtain the
9 services of a pharmacist on a part-time basis, but none
are available.

10 COMMISSIONER BALTZAN: Relative to your
11 last reference in connection with 1,743 beds, an exten-
12 sion of that problem, I realize that personnel and man-
13 power is of great interest to the health services, and
14 it is in that connection that I place this question to
15 you, and I ask first, a compounding of medications; the
16 old habitual form, has been greatly reduced; the pres-
17 criptions are not being so written as to have the pharma-
18 cist compound so many drugs, which is time-consuming; is
that correct?

19 MR. OLIVER: That is right.

20 COMMISSIONER BALTZAN: Has this, then,
21 reduced in number the pharmacists required in any large
22 pharmacy and that whereas two or three pharmacists might
23 have worked on the rolling of pills as they used to, and
24 mixing, now they can go to the shelf and pick up a lot
25 of the things? For that reason, in any large pharmacy,
26 one might take the place of two or three?

27 MR. OLIVER: I don't think there has been
28 any reduction, sir, in the number of pharmacists.

29 COMMISSIONER BALTZAN: So that situation of
30 the new form in which drugs are available has not reduced
that requirement of druggists?



MR. LIVACK: Correct. This is the type of thing we would recommend, and I think this will come about eventually. I think the problem had been to obtain pharmacists for these small institutions. I think several smaller ones would like to obtain the services of a pharmacist on a part-time basis, but none are available.

COMMISSIONER BALDWIN: Relative to your last reference in connection with 1,743 beds, an extension of that problem, I realize that personnel and manpower is of great interest to the health services, and it is in that connection that I place this question to you, and I ask first, a compounding of medications, the old habitual form, has been greatly reduced; the prescriptions are not being so written as to have the pharmacist compound so many drugs, which is time-consuming; is that correct?

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4 MR. OLIVER: No.

5 COMMISSIONER BALTZAN: Just to continue
6 that, in these places where drugs are being dispensed,
7 are they being compounded or are they just being taken
8 off the shelf -- the nurse may go downstairs, and the
9 doctor had written a prescription, and all she has to do
is be sure she picks up the right package?

10 MR. OLIVER: You are referring to hospitals?

11 COMMISSIONER BALTZAN: Yes.

12 MR. LITVACK: I think in the main, I
13 believe a survey of a few years ago showed about 90% of
14 the prescriptions being dispensed are those already manu-
15 factured by the large manufacturing houses, but I think
16 there is another problem aside from the dispensing itself.
17 There is also an educational problem which arises, and
18 this is a question of dosage forms, over-dosage, under-
19 dosage, therapeutic dosage, and things of that nature,
20 and I think these are also becoming the problem. The
21 pharmacist at the present time must devote more of his
22 time to information for himself and for the medical man.
23 We find this to be a big factor within the hospital
24 itself -- an educational problem to the nursing and
25 medical staff, and we are dealing in an era of medication
26 which is ever-changing. You have new medication being
27 introduced almost every week, and it is for the pharma-
28 cist to be able to relate this information to the nursing
and medical authorities at the hospital. So, we are
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29 THE CHAIRMAN: Just on that point, did I
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3 understand you correctly that the ratio or percentage of
4 compounded prescriptions was 10% compounded and 90%
5 pre-compounded?

6 MR. LITVACK: This would not be exact,
7 but I think it is reasonably correct.

8 THE CHAIRMAN: On the matter of the use
9 of the prescription, that is, whether I take one pill
10 or whatever it may be every four hours, and so forth,
11 is that determined by the druggist or by the doctor?

12 MR. LITVACK: Well, the doctor ---

13 THE CHAIRMAN: Initially, on the prescrip-
14 tion?

15 MR. LITVACK: Yes. When the doctor writes
16 the prescription, he determines the dosage to be used,
17 but at times, if he is uncertain, he may wish to consult,
18 and this is where the pharmacist comes into the picture.

19 THE CHAIRMAN: But originally that is the
20 doctor's responsibility?

21 MR. LITVACK: That is right.

22 MR. OLIVER: If an error occurs, the
23 druggist is responsible.

24 THE CHAIRMAN: Pardon?

25 MR. OLIVER: If there is an error the
26 pharmacist is responsible.

27 THE CHAIRMAN: Well, it all depends. I
28 would not accept that as a complete legal proposition.
29 I don't think Mr. Deakin would, either.

30 MR. OLIVER: I would be afraid he might.

THE CHAIRMAN: It is much better that
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4 COMMISSIONER BALTZAN: Gentlemen, on page
5 18, F(b): "Experience under the Manitoba Medicare Plan
6 has shown that the cost of free medication under that
7 plan has far exceeded what was anticipated". Have you
8 any ideas whether that is because people have not the
9 means to obtain these medications? Is that why it has
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10 MR. OLIVER: I think there has been an
11 increased usage over what they anticipated. I think
12 they anticipated a certain amount of prescriptions per
13 population under the Medicare Plan, and this is more
than what they anticipated.

14 COMMISSIONER BALTZAN: Lastly, and I
15 would like to come back to the first thing just to have
16 it clear in my mind, that proposition in connection with
17 the prescription of a certain name product: my question
18 is, would you consider that the first pharmacist who
19 dispensed the prescription was a party to the promotion
of this registered product -- the first pharmacist?

20 MR. OLIVER: You are referring to the
21 Clindex deal?

22 COMMISSIONER BALTZAN: Yes.

23 MR. OLIVER: He was not an interested
24 party financially.

25 COMMISSIONER BALTZAN: But he was a party --

26 MR. OLIVER: He was merely doing his duty
as a pharmacist in the particular pharmacy.

27 COMMISSIONER BALTZAN: And because it was
28 a doctor's prescription he was obliged to?

29 MR. OLIVER: Yes.
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COMMISSIONER BALTIMORE: Gentlemen, on page

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3 COMMISSIONER BALTZAN: He had no power or
4 discretion in the matter?

5 MR. OLIVER: That is right.

6 COMMISSIONER FIRESTONE: Mr. Chairman, if
7 I may address a question to Mr. Oliver and his associates,
8 is the Manitoba Pharmaceutical Association in favour of
9 a prepaid drug plan for the Province of Manitoba?

10 MR. OLIVER: We would be with certain
11 reservations.

12 COMMISSIONER FIRESTONE: Could you elaborate
13 please what your reservations are?

14 MR. OLIVER: I think if our Association
15 was involved in an overall prepaid medicine plan, in
16 which pharmaceutical services were included, we would
17 insist we have representation on the Board governing
18 that administration. We would think that all the profes-
19 sions should be represented on that Board, and that no
20 one profession should have a majority. They would all
21 be equally represented.

22 COMMISSIONER FIRESTONE: Do you feel if a
23 prepaid drug plan were developed for the Province of
24 Manitoba the pharmacists should be represented on the
25 Board or agency that would administer such a plan?

26 MR. OLIVER: Yes.

27 COMMISSIONER FIRESTONE: And should be
28 adequately represented?

29 MR. OLIVER: That is right.

30 COMMISSIONER FIRESTONE: Would you feel
that such a plan should include a deterrent to avoid
misuse of such a plan?



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4 MR. OLIVER: Evidence has shown that in
5 other countries where these prepaid pharmaceutical
6 services are engaged, that a deterrent fee has been a
7 must. Further than that, it is difficult for us to add
8 to that, but it would appear it is a necessity.

9 COMMISSIONER FIRESTONE: Have you any views
10 of what such deterrents should be and, if you have not,
11 could you, after further consideration, give us your
12 view?

13 MR. OLIVER: We would be very glad to.

14 COMMISSIONER FIRESTONE: In writing on a
15 subsequent occasion?

16 MR. OLIVER: In writing, yes sir.

17 COMMISSIONER FIRESTONE: If a prepaid drug
18 plan were considered, would you feel that such a plan
19 might be paid through the medium of premiums?

20 MR. OLIVER: I don't think we have informa-
21 tion at hand to make a statement on that. To my knowledge,
22 there is no plan we could refer to for guidance. It would
23 require a good deal of study, and we don't have the know-
24 how or the financial ability to carry that on.

25 COMMISSIONER FIRESTONE: May I help you:
26 would you say that such a plan would have to be paid
27 somehow or in some way, and those that can afford to pay
28 their contribution to the plan to receive these drugs
29 should do so?

30 MR. OLIVER: Yes, sir.

COMMISSIONER FIRESTONE: Would you say
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contribution to that prepaid drug plan, because of their

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3 low incomes and unemployment, welfare cases and what have
4 you, that in such cases the State should pay whatever
5 contribution is required?

6 MR. OLIVER: I believe that would be a
7 good approach, sir.

8 COMMISSIONER FIRESTONE: Mr. Oliver, have
9 you had an opportunity of seeing the statement that was
10 submitted to us by the Minister of Health and Welfare
11 of the Government of Manitoba with respect to drug
12 prices? Did you see that statement?

13 MR. OLIVER: Just when it was referred to
14 in the newspaper. I would not be prepared to make any
15 comment on it.

16 COMMISSIONER FIRESTONE: May I suggest to
17 you that we were advised that when the Government of
18 Manitoba called for public tenders for specific types
19 of drugs they found price differences up to and exceeding
20 400% for the corresponding drug. Assuming that the
21 information that was given to us by the Government of
22 Manitoba -- and I am quite sure that there is no reason
23 to doubt this information -- assuming this is a fact,
24 could you offer some explanations as to why there are
25 some such large differences of 400%-plus?

26 MR. OLIVER: I would not be in a position
27 to make a comment on it other than to say I believe
28 the representatives of the Canadian Pharmaceutical
29 Manufacturers' Association are going to be appear before
30 this Commission at a later date, and I think they are
the people who would be able to give you that information.

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COMMISSIONER FIRESTONE: Have you any



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3 suggestions how drug prices to the consumer could be
4 reduced?

5 MR. OLIVER: By remitting the sales tax;
6 that would be one.

7 COMMISSIONER FIRESTONE: Have you any
8 other suggestions?

9 MR. OLIVER: I don't think so, sir.

10 THE CHAIRMAN: Would you feel, for
11 example, that bulk purchasing might be a way of reducing
12 drug prices to the consumer?

13 MR. OLIVER: You mean a group of pharma-
14 cists getting together and purchasing on a bulk basis?

15 COMMISSIONER FIRESTONE: I leave the
16 methods of achieving the objective to your own ends;
17 this is a matter of principle. If there were drug
18 purchases on a bulk basis, whether that would be one
19 way in which the cost to the consumer of drugs could be
20 reduced?

21 MR. OLIVER: New regulations would eliminate
22 a great number of drugs, because you are not permitted to
23 join with the buying power of another store or pharmacy
24 in purchasing these drugs.

25 COMMISSIONER FIRESTONE: What kind of regula-
26 tions prevent pharmacists from purchasing drugs in bulk?

27 MR. OLIVER: Well, the federal laws
28 regarding control of drugs and narcotics is one.

29 COMMISSIONER FIRESTONE: What particular
30 aspect of the regulations prevents pharmacists from
purchasing drugs in bulk?

MR. OLIVER: When you order a controlled



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4 drug or narcotic drug for a single store, it must be
5 dispensed through that specific store.

6 COMMISSIONER FIRESTONE: If it is a
7 narcotic drug?

8 MR. OLIVER: Or a controlled drug.

9 COMMISSIONER FIRESTONE: Are there other
10 drugs that are prescribed by physicians and then
11 distributed and sold through pharmacists that could be
12 purchased on a bulk basis, and therefore bring a reduc-
13 tion in the sales price to the consumers?

14 MR. OLIVER: It would be a small portion.

15 COMMISSIONER FIRESTONE: Has any considera-
16 tion been given to the economies that can be achieved
17 through bulk purchasing by your own Association?

18 MR. OLIVER: No, not to my knowledge.

19 COMMISSIONER FIRESTONE: Are you aware of
20 any other provincial association having given some
21 thought to it or considering and trying it out on a
22 pilot plan basis?

23 MR. OLIVER: No, I am not, sir.

24 COMMISSIONER FIRESTONE: How about the
25 purchase of drugs and the sale of drugs by their generic
26 name as against brand names? Could economies be achieved
27 if more drugs were sold by the generic names than by the
28 brand names, and could these benefits be passed on to the
29 consumer in terms of lower drug prices?

30 MR. OLIVER: First of all, all trade name
drugs have a generic name on their label and they can be
considered generic names, but we would have to be
assured that these generic name drugs, that have come to



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4 be known through publicity in the papers, were of a suffi-
5 cient standard and therapeutic ability to qualify for
6 use in our store, and until the Food and Drug Department
7 is prepared to pass on that information, I would question
8 very much whether we would be interested in it.

9 COMMISSIONER FIRESTONE: Would you say
10 there are price differentials between what are called
11 drugs sold under brand names and drugs sold under
12 generic names?

13 MR. OLIVER: Yes, there are.

14 COMMISSIONER FIRESTONE: In other words,
15 if a method could be devised where you would, as a
16 responsible pharmacist, be convinced that a drug with a
17 generic name is equivalent in quality and effectiveness
18 to a brand drug, that you would be quite happy to dispense
19 that and sell it to the consumer at a considerably
20 lower price.

21 MR. OLIVER: I think this, that if these
22 drugs were tested and qualified, that the cost would go
23 up.

24 COMMISSIONER FIRESTONE: I did not hear
25 that.

26 MR. OLIVER: I would say, if these
27 generic names were tested and controlled that their
28 cost would go up considerably

29 COMMISSIONER FIRESTONE: This is a supposi-
30 tion of yours, but on the basis of facts as you know
them now, there is a substantial price differential,
as you have indicated; am I correct in that understanding?

MR. OLIVER: That is right.



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COMMISSIONER FIRESTONE: Therefore, the problem resolves itself into developing a system that will satisfy you as a pharmacist that these drugs sold under generic name have the same quality and the same effectiveness as has the other, say, with brand drugs?

MR. OLIVER: That is right.

COMMISSIONER FIRESTONE: Have you any suggestion, or has your Association any suggestions how such a system could be developed to the satisfaction of the Pharmaceutical Association in Manitoba and in other provinces of Canada, and if you have not given thought to such a possibility, could you give some thought to it and let us have your views in writing at a subsequent time?

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4 THE CHAIRMAN: Mr. Oliver, did I under-
5 stand that your Association takes the view that there
6 is a shortage of qualified druggists in Manitoba?

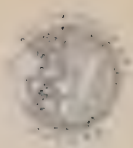
7 MR. OLIVER: I would like Dr. Murray to
8 answer that.

9 DR. MURRAY: In my opinion there is a
10 shortage and I am basing this opinion on the fact that -
11 this is just my third year in Manitoba but in the
12 graduating class we put through in 1960 and 1961 each
13 student had a choice of several positions, that is, we
14 could have placed more pharmacists. Therefore, from my
15 standpoint I feel there is a shortage judging by the
16 number of positions available to graduate students.
17 Our responsibility is, I suppose, twofold. And these
18 are not necessarily in order but perhaps in descending
19 order and perhaps equal. We have a responsibility to
20 provide enough pharmacists to look after the pharmaceu-
21 tical services required by the residents of Manitoba.
22 I also think we have a responsibility to provide pharma-
23 cists in other areas such as in positions with the food
24 and drug laboratories, positions with the narcotic
25 control in the inspection branch, pharmacists in industry
26 and in research and in teaching. There are apparent
27 shortages in all of these branches.

28 THE CHAIRMAN: Are you able to tell us
29 how many pharmacists are employed full-time in profes-
30 sional work?

DR. MURRAY: I do not have those figures,
perhaps some of the other members do.

MR. OLIVER: I take it you mean dispensing



stand that your Association takes the view that there

is a shortage of qualified druggists in Manitoba?

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3 only?

4 THE CHAIRMAN: Yes, or in these other
5 fields Dr. Murray referred to, teaching, quality control,
6 that kind of thing.

7 MR. ANDERSON: This is just for Manitoba?

8 MR. OLIVER: You are limiting it to Mani-
9 toba. We would not have those figures.

10 THE CHAIRMAN: Perhaps conversely what
11 is the percentage engaged in the retail dispensing drugs
12 part-time and selling other goods part-time?

13 MR. ANDERSON: At the present time we have
14 in Manitoba employed on a full-time basis as proprietors,
15 managers and employees in retail pharmacies and in hospi-
tals, 549 pharmacists.

16 THE CHAIRMAN: And in hospitals, how many
17 of them?

18 MR. ANDERSON: In hospitals we have 31
19 full-time.

20 THE CHAIRMAN: So we take them off?

21 MR. ANDERSON: Yes, it takes it down to
22 518 presently in what we regard as retail pharmacies.

23 THE CHAIRMAN: Are you in a position to
24 say how much a percentage, time-wise, in a given day or a
25 given year, that those pharmacists devote to pharmacy
as distinct from ordinary merchandising?

26 MR. ANDERSON: This, I find very difficult
27 because while we require that pharmacists be on duty
28 while the pharmacy is open and they are serving whenever
29 required, to break down his man-hours in a store would
30 be very difficult.

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4 THE CHAIRMAN: You see, our proposition
5 could come to this: that it costs a great deal of money
6 to train a pharmacist, both to the pharmacist himself
7 and to his State in capital expenditures and in the
8 operation of the educational institution. The question
9 can arise, is that total money being well spent if a
10 major part of this qualified pharmacist's time is in ordinary
11 merchandising?

12 MR. ANDERSON: Well, may I submit, sir,
13 while it may appear to some that a large part of his
14 time is employed with merchandising, I feel that through
15 his training and the class of business he operates a
16 great deal of his training is used in serving the public
17 in their common everyday needs through a drugstore.

18 THE CHAIRMAN: You mean health needs?

19 MR. ANDERSON: Yes. A great deal of his
20 time is devoted to the serving of the health needs from
21 the sale of health products, advice to the clientele
22 where they are not the patients of a medical practitioner
23 and this is now associated with actual dispensing.

24 THE CHAIRMAN: Now, if I might put a
25 question that you may or may not be able to answer at
26 the moment as to the value of the non-prescription drug
27 that is sold over the counter, could you give a total
28 for it in Manitoba, are you in a position to do that?

29 MR. OLIVER: That is dollar-wise?

30 THE CHAIRMAN: Yes.

MR. OLIVER: This is part of a survey
that the average prescription in Manitoba costs \$9.

THE CHAIRMAN: I am not talking about



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MR. OLIVER: That is rather wide.

THE CHAIRMAN: Yes.

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that the average prescription in Manitoba costs \$3.

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3 prescriptions, non-prescription.

4 MR. OLIVER: A figure roughly between 50%
5 and 60% of that amount would be 5.1/2 dollars or 6.1/2
6 dollars - would be an over-the-counter sale only in
7 drugstores. Now, many items - I hope you are referring
8 to aspirin and chest rubs and so on - these are all sold
9 by the supermarkets which we could not give you an esti-
10 mate of at all.

11 THE CHAIRMAN: And the news agencies?

12 MR. OLIVER: Yes, and door-to-door salesmen.

13 THE CHAIRMAN: But in your retail drug-
14 stores you think the figure would be half as much as a
15 prescription total?

16 MR. OLIVER: That is right.

17 COMMISSIONER STRACHAN: Referring to page
18 18E, has this Association made any effort provincially
19 to bring this recommendation about and, secondly, have
20 you trouble in getting fresh stock which has been properly
21 cared for in the wholesale? Is this a disturbing factor
22 to you?

23 MR. OLIVER: I would have to present a
24 personal opinion; I have seen drugs arrive at our place
25 of business where the dating was very short and it
26 should never have left the wholesale, in my opinion.

27 COMMISSIONER STRACHAN: And have you made
28 any effort to bring this recommendation about provin-
29 cially without going into the detail of it?

30 MR. OLIVER: No, we have not.

COMMISSIONER STRACHAN: Do we take it from
this that there are no qualified pharmacists in the

MR. CHAIRMAN: A figure roughly between 50%

and 60% of this amount would be 5.5% dollars or 6.1%

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MR. CHAIRMAN: No, we have not.

COMMISSIONER STRICKLAND: Do we take it from



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3 wholesale druggists?

4 MR. ANDERSON: Well, in Manitoba, under our
5 Act, a wholesale that operates a laboratory for the
6 manufacture of products must be manned by qualified
7 pharmacists. Our local wholesales, and in that I will
8 include distribution depots, the wholesales and some
9 of these distribution depots do provide this service
10 but there are others that do not. These people assume
11 this responsibility quite voluntarily and makes provision
12 but others because of lack of compulsion have ceased to
13 not do this.

14 COMMISSIONER STRACHAN: There are employees
15 employed who have no idea of how these products should
16 be stored and handled?

17 MR. ANDERSON: That could be, sir.

18 THE CHAIRMAN: Thank you very much,
19 gentlemen, for your assistance and for this additional
20 information that you are going to try and let us have.
21 You will, of course, do that through our Secretary at
22 the Ottawa office and we will appreciate having it as
23 soon as you can reasonably obtain it and send it in.
24 Again, thank you very much for the assistance you have
25 been to us.

26 We will now adjourn until 2 o'clock.

27
28
29 --- Luncheon adjournment
30

sale druggists?

MR. A. L. LAMONT: Well, in Manitoba, under our

manufacture of products must be handled by qualified
pharmacists. Our local wholesalers, and in that I will
include distribution depots, the wholesalers and some
of these distribution depots to provide this service
but there are others that do not. These people assume
this responsibility quite voluntarily and makes provision
but others because of lack of compulsion have ceased to
not do this.

employed who have no idea of how these products should
be stored and handled?

MR. ALDERMAN: That could be, sir.

Gentlemen, for your assistance and for this additional
information that you are going to try and let us have.
You will, of course, do that through our secretary at
the Ottawa office and we will appreciate having it as
soon as you can reasonably obtain it and send it in.
Again, thank you very much for the assistance you have
been to us.

We will now adjourn until 2 o'clock.

--- Luncheon adjournment



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4 --- On resuming at 2 p.m.

5 THE CHAIRMAN: We will now hear from the
6 Associated Hospitals of Manitoba.

7 THE SECRETARY: This will be Exhibit No.
8 70 sir.

9 --- EXHIBIT NO. 70: Submission of the Associated
10 Hospitals of Manitoba.

11 SUBMISSION OF THE ASSOCIATED HOSPITALS OF MANITOBA

12 Appearances: Mr. G.B. Rosenfeld
13 Dr. L.O. Bradley
14 Dr. P. L'Heureux
15 Mr. C. Grierson

16 MR. ROSENFELD: Thank you Mr. Chairman.
17 I would like to introduce Dr. Bradley, who assisted in
18 the preparation of this brief, and Dr. L'Heureux, the
19 Vice-President of our Association.

20 On behalf of the 86 hospitals in Manitoba
21 which it represents, the Associated Hospitals of Manitoba
22 (A.H.M.) wishes a warm welcome to the members of the
23 Commission to our Province, and offers its complete
24 co-operation and services.

25 As a member of the Canadian Hospital
26 Association (C.H.A.) we have been advised of, and are
27 participating in, the comprehensive brief which it will
28 be presenting to the Commission. We do not wish to
29 duplicate the information which you will receive from
30 C.H.A. and will limit our observations to a few problems
which may not be covered in the C.H.A. brief, or have
particular importance in the Province of Manitoba.

The distribution of health care services



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3 is dependent to a very large degree on the geography,
4 population and local resources of the area involved.

5 In our Province, Hospitals have historically
6 been built upon the major highways of the Province. The
7 distribution of hospitals throughout the Province has to
8 some extent been influenced by the desire and ability
9 of local communities to build Hospitals as well as the
10 assistance of Governments in the cost of construction.

11 Recently, however, a survey of Hospitals
12 and their projected growth for the next five years was
13 undertaken by the Manitoba Hospital Survey Board and we
14 believe that the Report of this Board will prove to be
15 with rare exception the guide of our Government in deter-
16 mining the growth and development of Hospitals in the
17 future.

18 For many years, we have heard the principle
19 proclaimed of the rights of all citizens to equal oppor-
20 tunities for health services. We have no quarrel with
21 this principle and it is an ideal which we must forever
22 try to reach. We feel, however, that in sparsely settled
23 areas in our Province, it is impossible of attainment.
24 In practice, it will always remain impossible to have
25 at the immediate disposal of the residents of our
26 Northern Territories and other sparsely populated areas,
27 the same hospital facilities that are enjoyed for
28 example by the residents of major urban areas.

29 Our fear is that in an effort to attain
30 equal services for all, the available resources may be
diluted so widely that it may well result in a lowering
of the standards in the more specialized hospitals.

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For many years, we have heard the principle proclaimed of the rights of all citizens to equal opportunities for health services. We have no quarrel with this principle and it is an ideal which we most fervently try to reach. We feel, however, that an equally settled areas in our Province, it is impossible of attainment. In practice, it will always remain impossible to have

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4 The long-term goal should not be equal
5 hospital services for all, in terms of geography, but
6 rather adequate and basic facilities for all, with the
7 highest possible standards in the major centres of
8 medical care, to which all citizens may have reasonably
9 quick access.

10 Improved highways and better methods of
11 transporting the sick persons to larger centres may be
12 more important than the supplying of all health services
13 in every community, small or smaller.

14 The Associated Hospitals of Manitoba
15 believes that an increase in public health nursing can
16 reduce the need for additional acute general or convales-
17 cent beds required by the population. While it may be a
18 social mores of the community that diseases of all types
19 shall be treated in acute general hospitals, it may be
20 necessary and advantageous to educate the public and
21 others that certain ailments and diseases can just as
22 readily be treated in chronic, or convalescent hospitals
23 or in the home when public health nurses, V.O.N., and
24 home care programmes are available.

25 The availability of adequately developed
26 and accepted preventive services such as clinics and
27 well baby centres can reduce the requirements for
28 hospital care.

29 It may be useful to recount at some length
30 the basic ingredients and relationships that exist and
are part of hospital service. Traditionally, a group of
local citizens, sometimes aided and abetted by the local
doctor(s) responded to community need by organizing,



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4 financing, and erecting a community hospital. It cannot
5 be stated too often that the citizens of Manitoba owe
6 a great deal to voluntary boards and local Municipal
7 boards for the steady maintenance and improvement in
8 hospital service over past decades. To the combination
9 of Hospital authorities and Medical Profession must be
10 added, the nursing profession. Over the years a sound
11 system of hospital care has been developed which was
12 inexpensive and of a good standard. At times, before
13 1948, and since then, there has been assistance from
14 Provincial and Federal Government, in the form of construc-
15 tion grants. It can be stated, however, that the role
16 played by senior governments before the installation of
17 the Manitoba Hospital Services Plan on July 1, of 1958,
18 was not a very active one. Yet, it must be recalled
19 that hospital service had undergone remarkable improvement
20 during the last fifteen years particularly, despite very
21 difficult financial circumstances.

22 At the Provincial level, an excellent
23 working relationship, has gradually evolved between the
24 three organizations basically involved in hospital
25 service, viz.: Associated Hospitals of Manitoba, the
26 Manitoba Medical Association, and the Manitoba Associa-
27 tion of Registered Nurses. Since the establishment of
28 M.H.S.P. in 1958, this relationship has grown and
29 matured, first to build up a more effective working
30 relationship, and then to present a common approach to
the newcomer in the hospital field. The M.H.S.P. as
successor to the Blue Cross of Manitoba is more imposing
because it is cloaked by more comprehensive legislative



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3 powers, and as a result there is a feeling of uneasiness
4 concerning the abilities of Board of Trustees to act.

5 The sudden entrance into the hospital
6 service of this young giant, with a complete armamentarium
7 of financial and regulatory controls has relieved to a
8 major degree the very heavy burden of operating funds
9 which were a perennial problem of all hospitals. There
10 has not, however, been a parallel gain in the availability
11 of capital funds, largely because of public misunderstan-
12 ding. It should be stated that a good measure of
13 co-operation has existed between the Plan on the one hand,
14 and the hospitals and their Association on the other hand.
15 The Association is not unaware of the conditions imposed
16 upon the Plan by Government. There is the requirement
17 of unlimited services dictated by public demand and the
18 great difficulty of controlling the total cost of an
19 expanding and extending service. The normal and natural
20 reaction to these demands has been an increasing degree
21 of centralization, with its attendant difficulties.

22 It is with this trend of affairs, that
23 the Association is deeply concerned. If it continues
24 to grow, there will be a corresponding decline in local
25 interest and responsibility and probably in the quality
26 of hospital service. The Association believes that the
27 preservation of local autonomy, interest and responsi-
28 bility is a fundamental requirement to good hospital and
29 medical service. The Association believes that the
30 Governments must be integrated into the traditional
partnership rather than imposed as a dominant partner.

We believe that all members of this

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service of this young giant, with a complete abandonment of financial and regulatory controls has relieved to a major degree the very heavy burden of operating funds which were a perennial problem of all hospitals. There has not, however, been a parallel gain in the availability of capital funds, largely because of public misadventure.

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the Association is deeply concerned. It is anxious to grow, there will be a corresponding decline in local interest and responsibility and, finally, in the quality of hospital service. The Association believes that the preservation of local autonomy, interest and responsibility is a fundamental requirement to good hospital and medical service. The Association believes that the Government must be integrated into the traditional partnership rather than imposed as a dominant partner. We believe that all members of this



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3 partnership would benefit by the creation of a Provincial
4 Health Council designed to co-ordinate the activities
5 of all those interested in health care in the Province
6 and whose prime concern would be the education of the
7 public in all matters concerning health.

8 We believe that education and co-operation
9 will in the end prove more fruitful than regulation and
10 authoritarian decision.

11 We wish to commend in particular the
12 Manitoba Medical Association and the Manitoba Association
13 of Registered Nurses who have for many years co-operated
14 with hospital boards in evolving a pattern of care in
15 Manitoba that has resulted in 73.4% of the eligible beds
16 in Member Hospitals being Accredited by the Canadian
17 Council on Hospital Accreditation and with whose co-opera-
18 tion it is hoped that in the near future over 90% of all
19 eligible beds will eventually be Accredited.

20 We also wish to inform the Royal Commission
21 on Health Services that while there may be differences
22 of opinion from time to time with the Manitoba Hospital
23 Services Plan, the Associated Hospitals of Manitoba goes
24 on record as stating that the Hospital Insurance Plan as
25 has been carried out by the Province of Manitoba under
26 Bill 320 has proved to be one that has met with general
27 satisfaction from the Board of Trustees of Hospitals.

28 It is hoped that any plan that is evolved through the
29 deliberations and recommendations of the Royal Commission
30 on Health Services will recognize the fact that co-opera-
tion between those interested in the maintenance and
growth of the hospitals in the Province of Manitoba can



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Growth of the hospitals in the Province of Manitoba can



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3 best be achieved by continued and intensive education of
4 the public, by the encouragement of voluntary bodies and
5 by the introduction and endorsement of minimum rather
6 than maximum standards.

7 Let us be certain that adequate care is
8 available to all and the natural ambition, courage and
9 devotion of local trustees, and other health personnel,
10 as well as the general public will see to it that stan-
11 dards are raised smoothly and continuously as demanded
12 by the progress of medical science.

13 THE CHAIRMAN: Thank you very much Mr.
14 Rosenfeld.

15 MR. HALL: Mr. Chairman, I understand that
16 the members of the Commission and the research staff
17 are interested in acquiring information in regard to the
18 cost of improper use of hospital beds, and although this
19 does not arise directly out of the brief which has been
20 presented, I would ask your permission to pursue a line
21 of interrogation along those lines.

22 THE CHAIRMAN: Do you gentlemen agree with
23 that?

24 MR. ROSENFELD: I hope the Commission will
25 realize, Mr. Chairman, that these will be personal
26 opinions and not those of the Association or the hospitals.

27 MR. HALL: I understand that there has
28 recently been a research program carried out by the
29 University of Michigan under the direction of Dr.
30 McInerney, known as the Character and Effectiveness of
Hospital Use. Are you acquainted with that research
project?

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3 DR. BRADLEY: I am familiar with it.

4 MR. HALL: I am introducing some statistics
5 at this time, Mr. Chairman, to give the members of the
6 Commission a background against which to assess any
7 information which may come out.

8 I understand that that project arrived at
9 the conclusion that in the State of Michigan, in 85% of
10 non-surgical cases in hospital, there was an appropriate
11 length of stay; is that correct according to your under-
standing?

12 DR. BRADLEY: That is right.

13 MR. HALL: And that in non-surgical cases,
14 in 7% of the cases there was under-stay, is that correct?

15 DR. BRADLEY: That is right.

16 MR. HALL: And that in 8% of the non-
17 surgical cases there was over-stay, is that correct
Doctor?

18 DR. BRADLEY: Yes.

19 MR. HALL: And I understand also that they
20 found that in-surgical cases, 81% had an appropriate
21 length of stay, is that correct?

22 DR. BRADLEY: That is right.

23 MR. HALL: And in 6.1/2% of the surgical
24 cases there was under-stay?

25 DR. BRADLEY: Yes.

26 MR. HALL: And that in 12.1/2% of the
surgical cases there was over-stay?

27 DR. BRADLEY: Yes.

28 MR. HALL: And for the purposes of the
29 inquiry, and for our discussion, over-stay perhaps
30



MR. HALL: I am introducing some statistics at this time, Mr. Chairman, to give the members of the Commission a background against which to assess any information which may come out. I understand that that report arrived at the conclusion that in the State of Michigan, in 32% of non-surgical cases in hospital, there was an appropriate length of stay; is that correct according to your understandings?

DR. BRADLEY: That is right. MR. HALL: And that in non-surgical cases, in 7% of the cases there was under-stay, is that correct? MR. HALL: And that in 8% of the non-surgical cases there was over-stay, is that correct?

MR. HALL: And I understand also that they found that in surgical cases, 81% had an appropriate length of stay, is that correct? DR. BRADLEY: That is right. MR. HALL: And in 8.1% of the surgical cases there was under-stay? DR. BRADLEY: Yes. MR. HALL: And that in 12.1% of the surgical cases there was over-stay?

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4 could be defined as a situation arising when a patient
5 is occupying a bed unnecessarily, or when he no longer
6 needs to be cared for in a hospital; would that be a
7 correct definition Doctor?

8 DR. BRADLEY: Yes.

9 MR. HALL: And for the purposes of this
10 discussion too, we could distinguish between acute
11 cases and chronic cases, the definition of an acute
12 case being one who occupies a bed for a short term, and
13 requires concentrated care, that is one who occupies a
14 bed around which are concentrated facilities for diag-
15 nosis, such as x-rays, and so on, is that correct?

16 DR. BRADLEY: Yes.

17 MR. HALL: Are you able to tell us from
18 your experience and information whether you have found
19 that there is any significant amount of over-stay in
20 your hospitals?

21 DR. BRADLEY: Mr. Chairman, I would first
22 like to say to the Commission that this source of infor-
23 mation, which was the outcome of a half-million dollar
24 study in Michigan during the last four years, became
25 available to me by good fortune in November, and because
26 of the interest of the research staff of the Commission
27 in it, I made it immediately available to the Commission,
28 and my survey of it is probably less accurate than that
29 of your counsel.

30 The printed report, I am told, will be
available some time about the 1st of February, and I
would suggest, sir, that there might be very much useful
information that might be useful to the Commission in

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3 its deliberations, and I am sure it will be readily
4 available to you.

5 The question of utilization, I think you
6 will appreciate, is not something that can be determined
7 quickly or easily, since a good deal of it must rest on
8 the judgment of the physician who is doing the survey,
9 or a battery of physicians, or in this study, a set of
10 average standards which were set up by learned specialists
11 in the various fields. This study was applied to a wide
12 variety of hospitals, from large to small. The problems
13 that were involved in it were the problems of the impact
14 of teaching, which tended to increase the length of stay,
15 the degree of specialization, which tended to increase
16 the length of stay. Interestingly enough, the length of
17 stay tended to increase where there were young specialists,
18 recently trained, who were using the whole book of medicine,
19 because probably, and I might say their judgment was not
20 as sure as that of their older confreres. The difficulty
21 in any such study again is the application of the medical
22 mores of the community, to agree to the time of discharge,
23 and the evaluation of a panel coming from outside, no
24 matter how expert, cannot always reflect the practice in
25 that community, and this provides real difficulty.

26 There is no question that the difference
27 in percentages here, when applied to a large number of
28 people and the cost of hospital care today is the signifi-
29 cant cost to the community as a whole, and should be
30 looked at very carefully.

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4 I think it has been brought to your
5 attention by a number of agencies, Government and other-
6 wise, in Manitoba, that the availability of other facili-
7 ties in the community has a very major impact here. If
8 the availability of hospitals, or convalescent beds are
9 not available, or nursing home beds are not available,
10 there is a natural tendency to extend the stay in the
11 general hospital, and I think this has been amply stated
12 by others, and I think we would say as individuals, and
13 as an Association, that we support the view to the Royal
14 Commission of our own government of greater emphasis in
15 this area.

16 One other factor that is a greater intan-
17 gible, and this is the availability of quality diagnostic
18 services in the hospitals where in readiness the availabi-
19 lity of the service is not up to par, you can understand
20 the diagnosis is not as effective or early, and the cases
21 may not be brought to the core of the matter soon enough.
22 I think the other aspect of this which has to do with
23 cost particularly, is not only the utilization of the bed
24 for the day and all the expenditure this makes necessary,
25 but the utilization of both the service, both diagnostic
26 and treatment, that are now accumulating in hospital.
27 There is undoubtedly some over-utilization of diagnostic
28 services because these are not available on a prepaid
29 basis outside a hospital, and you find in some hospitals
30 over-utilization in x-ray and laboratory services than
you would otherwise expect.

THE CHAIRMAN: Do you find, Dr. Bradley,
any substantial evidence of patients either being put in



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One other factor that is a greater intangible, and this is the availability of quality diagnostic services in the hospitals where in readiness the availability of the service is not up to par, you can understand the diagnosis is not as effective or early, and the cases may not be brought to the care of the patient soon enough.

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There is undoubtedly some over-utilization of diagnostic services because these are not available on a prepaid basis outside a hospital, and you find in some hospitals over-utilization in x-ray and laboratory services than you would otherwise expect.

THE CHAIRMAN: Do you find, Dr. Bradley, any substantial evidence of patients either being put in



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4 hospital or insisting on going to hospital for x-ray and
5 diagnostic procedures that might well be done outside
6 the hospital, merely because hospitalization is paid for
7 and the other aspect is not?

8 DR. BRADLEY: I think this is a little
9 difficult to answer generally. I think where there is
10 a pressure on beds for acute care, as there is in this
11 community, this is less a factor because the doctors,
12 as a group, working through their hospital organization,
13 wish to preserve these beds for the time of need for
14 acute illnesses. However, unquestionably, where the bed
15 pressure is not so great, that may well be, although I
16 think in total this is not the major abuse. Perhaps the
17 over-utilization, once in, is the greater abuse.

18 DR. L'HEUREUX: Mr. Chairman, we may
19 perhaps cite one example of that at our own hospital in
20 St. Boniface, where on two separate occasions we tried
21 to have surveys made by two different teams of doctors
22 so that the same interpretation would not be put on it
23 both times. We excluded from this survey the maternity
24 and psychiatric and communicable disease cases, and such
25 wards that are really outside the normal type of medical
26 care, and we were left with roughly 400 patients, and
27 the survey showed roughly 18% of these were what we may
28 call over-stayed, and these were divided into roughly
29 thirds. One-third was over-staying because there was no
30 other place to place these people -- chronics and long-
term cases waiting to be placed in an institution; one-
third roughly were cases which we thought were in mainly
for diagnostic types of things that could have been done

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think in total this is not the major aspect. Perhaps the
over-utilization, once in, is the greater aspect.

Mr. L'Abbate: Mr. Chairman, we may
perhaps cite one example of that in our own hospital in
St. Boniface, where on two separate occasions we tried
to have surveys made by two different teams of doctors
so that the same interpretation would not be put on it
both times. We excluded from that survey the maternity
and psychiatric and communicable disease cases, and also
wards that are really outside the normal type of medical
care, and we were left with roughly 500 patients, and
the survey showed roughly 15% of these were what we may
call over-stay, and these were divided into roughly
three things. One-third was over-staying because there was no
other place to place these people - oncology and long-
term cases waiting to be placed in an institution; one-
third was waiting to be placed in an institution; one-
third was waiting to be placed in an institution.



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3 in the doctors' offices or elsewhere; and one-third were
4 simply over-staying -- these were ready to go home and
5 had no other excuse for being in the hospital.

6 So, that brings it down to about 6% of the
7 400 in the category which counsel was mentioning a little
8 while ago.

9 MR. ROSENFELD: Surveys done in our own
10 institution have reflected on the question of utilization
11 of the facilities immediately available to the doctor in
12 his own office as well as whether the patient who entered
13 the hospital was or was not covered by M.M.S. We have
14 done samplings in our own institution and have shown that
15 a lesser number of pre-surgical tests or medical tests
16 are done on those patients who do have M.M.S. than those
17 who do not have M.M.S.

18 I would like to make one other comment
19 about over-utilization of tests or development of tests
20 and the pattern of the growing use of tests in some
21 instances, and I speak with a little personal experience
22 in a number of hospitals in this area, where the introduc-
23 tion of a standards committee within the hospital and the
24 introduction of a tissue committee within the hospital
25 can show as well an increase in the number of tests per-
26 formed for formal documentation in many instances.

27 THE CHAIRMAN: You gentlemen will appre-
28 ciate, of course, that the interest of this Commission
29 in this subject is necessarily a very substantial one,
30 because in round figures the bill for hospitalization in
the general hospitals across Canada is in the order of
about \$675,000,000 a year, and that even a 6% or 10%



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THE CHAIRMAN: You gentlemen will appreciate, of course, that the interest of this Commission in this subject is necessarily a very substantial one, because in round figures the bill for hospitalization in the general hospitals across Canada is in the order of about \$65,000,000 a year, and that even a 6% or 10%



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4 over-utilization is reflected in \$50 to \$75 or \$100 million,
5 and those are figures that are of importance in the over-
6 all picture.

7 DR. BRADLEY: Mr. Chairman, I think it is
8 well-known, and it has been frequently stated here in
9 the last ten years, that because of the lack of alternative
10 facilities that we undoubtedly are poorly using our
11 general hospitals. However, I think, as you stated, a
12 very substantial amount that can be overspent is a matter
13 of real concern, and while my confreres and I state the
14 general principles, and perhaps state rather specifically
15 for one or two institutions, the degree and extent of
16 this, I think probably the Commission or the Department
17 of National Health and Welfare may very well be charged
18 with a closer and continuing examination of this because,
19 unquestionably, the saving of a very small percentage
20 could effect a very considerable savings in funds and
21 direction of policy to this end.

22 MR. ROSENFELD: Mr. Chairman, I would like
23 to add to that, if I may, with this comment, that in the
24 study of services rendered in acute general hospitals and
25 the cost distribution of these services, the longer term
26 care patient who stays in the acute general hospital, if
27 one was to cost their services, would be less than the
28 short-term surgical admission, and I wish to draw to the
29 attention of this Commission that if these patients are
30 withdrawn from the normal spread on services rendered in
the hospital, it appears that the cost per day in the
hospital will increase for those remaining in the hospital,
because they will be taking out the lower end cost of a

over-utilization is estimated in 1955 to 1956 or \$100 million and those are figures that are of importance in the overall picture.

MR. BRADLEY: Mr. Chairman, I think it is well-known, and it has been frequently stated here in the last ten years, that because of the lack of alternative facilities that we undoubtedly are poorly using our general hospitals. However, I think, as you stated, a very substantial amount that can be developed as a matter of real concern, and while my conference and I state the general principles, and perhaps state rather specifically for one or two institutions, the degree and extent of this, I think probably the Commission on the Department of National Health and Welfare may very well be charged with a closer and continuing examination of this because, unquestionably, the saving of a very small percentage could effect a very considerable savings in funds and direction of policy to this end.

MR. ROSENBERG: Mr. Chairman, I would like to add to that, if I may, with this comment, that in the study of services rendered in acute general hospitals and the cost distribution of these services, the longer term care patient who stays in the acute general hospital, if one was to cost these services, would be less than the short-term surgical admission, and I wish to draw to the attention of this Commission that if these patients are withdrawn from the normal spread on services rendered in hospital will increase for those remaining in the hospital because they will be taking out the lower end cost of a



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3 spread, if you will, sir.

4 So, I think the Commission should recog-
5 nize this fact in evaluating, that mainly an increase in
6 hospital costs, if a long-term patient is removed in the
7 acute general hospital -- that there will be a saving to
8 the community, but there will be an additional cost in
9 the hospital.

10 THE CHAIRMAN: But might that result in
11 a lesser demand for beds?

12 MR. ROSENFELD: Yes, sir.

13 COMMISSIONER McCUTCHEON: When you say an
14 increase, I can see where there might be a per diem
15 increase.

16 MR. ROSENFELD: Yes, sir.

17 COMMISSIONER McCUTCHEON: But there will
18 be an absolute reduction?

19 MR. ROSENFELD: In the total health cost
20 there will be an absolute reduction, but there will be
21 an increase in the portion allocated to the acute general
22 hospital, sir.

23 MR. HALL: Have you, in your hospital,
24 made any study of this problem, or any analysis in regard
25 to a particular type of patient?

26 MR. ROSENFELD: Are you speaking of the
27 disease of the patient, or of general classification by
28 M.M.S. or non-M.M.S.?

29 MR. HALL: Either way.

30 MR. ROSENFELD: Yes, we have.

MR. HALL: Could you give us the benefit
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4 MR. ROSENFELD: Yes sir, I will formalize
5 it and submit it to the Commission at your request.

6 MR. HALL: Is there any way of determining
7 what the average length of over-stay might be?

8 MR. ROSENFELD: No, we have not examined
9 it in this sphere. Where we have examined it is in the
10 utilization of laboratory and x-ray services in relation-
11 ship to the patient and the doctor, not into the area of
12 length of stay, although we did make a study in specific
13 instances of disease such as hernia.

14 MR. HALL: Could you give us an example
15 of that?

16 MR. ROSENFELD: Yes. We did a survey in
17 the specific area of a simple hernia and found there was
18 a plateau in the days of discharge between four and eight.
19 Beyond that there was an extension of days. But, the
20 two peaks in terms of discharge were four and eight days,
21 and we examined the range between those, and those making
22 the study felt there were no criticisms or condemnation
23 could be made within this range; and then there was an
24 over-utilization in some instances similar to what Dr.
25 L'Heureux and Dr. Bradley have pointed out.

26 MR. HALL: Could you submit it to the
27 Commission in a supplementary submission?

28 MR. ROSENFELD: I will make a personal sub-
29 mission, sir.

30 MR. HALL: Are you able to offer to the
Commission any suggestions in what way over-stay could
be controlled if it is found to be prevalent?

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3 gentlemen as people who are operating the program at the
4 utilization level.

5 MR. ROSENFELD: In our brief to the
6 Commission, sir, we discuss in one chapter the question
7 of the social mores of the community. I think for a
8 number of decades now people have been educated that
9 if they are sick, and particularly sick, one of the best
10 places for them is the acute general hospital. One of
11 the main reasons for this has been that we have not had,
12 unfortunately, a number of beds equal to the demand for
13 intermediate care, nor have many of these institutions
14 been of acceptable standards. Therefore, the community
15 feels the only place they can get acceptable care is in
16 the acute general hospital, and in discussing this with
17 members of the medical profession they feel if there were
18 acceptable high standards in convalescent and chronic
19 care institutions they could very well assist in changing
20 the attitudes of their patients so they could be trans-
21 ferred to these institutions, but at the present time the
22 social mores of the community and the lack of these
23 specific facilities, accredited standards, in adequate
24 numbers, places this question in the hypothetical sense.
25 It is the feeling in discussion of evaluation of these
26 cases that this could be done.

27 One further statistic I could offer to you
28 is that 4% of the patients in our hospital stayed longer
29 than 30 days, but these 4% of patients used up 17% of the
30 hospital days in the hospital: 4% of the patients stayed
longer than 30 days, but this 4% used up 17% of the
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Gentlemen as people who are operating the program at the utilization level.

MR. ROSEBLUTH: In our brief to the

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4 DR. BRADLEY: Necessarily, Mr. Chairman
5 these are general answers. The one action taken by our
6 plan here is worthy of wider consideration, and this is
7 the establishment of day care or the parallel to day care,
8 the enablement to the individual of minor services of the
9 hospital without admission, and, as you have now known
10 through the submission of the Manitoba Government, there
11 is a list of 40 or 50 minor procedures which are paid for
12 when done at the hospital, and unquestionably this
13 reduces the demand for admission. Again, this probably
14 affects the total increase in the community spending on
15 health, and yet the return is an economical spending.
16 Again, this is a matter of degree, as it varies between
17 urban and rural centres in the province; the provision
18 of diagnostic services may well reduce the demand for
19 admission. I think it must be realized that this cannot
20 be arbitrarily drawn, because diagnostic procedures are
21 becoming much more complex, of equipment and of staff,
22 and that there is necessity for a lot of them to be
23 admitted yet for basic evaluation. However, for a lot
24 of the average type of illnesses in the preventive stage
25 this may very well save time.

26 I would reinforce what Mr. Rosenfeld said
27 about the education of the public on the use of these
28 facilities. It has to be a broad, shotgun approach by
29 all involved -- hospital, doctor, and so on. Unquestio-
30 nably, the provision of quality alternative facilities is
important. The feeling of the average person in the
community that the care he may expect in convalescent and
chronic nursing homes is a very low opinion, and there is

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4 a very natural status and personal rejection of these
5 places -- fire dangers, poor quality of nursing care,
6 poor quality of dietary services -- though, at the same
7 time, I must add there are some excellent ones among
8 them.

9 I think the other area that has been
10 alluded to by earlier presentations is the dignifying of
11 home care, and staying at home and providing the services
12 there. Fortunately, the economics of the family and
13 the economics of the doctor tend to hospital centre the
14 practice of medicine, and there may be good reason for it,
15 but unquestionably the care of a person at two places,
16 or the maintenance of two beds -- one at home and one at
17 the hospital -- is of total greater cost to the community.

18 DR. L'HEUREUX: Mr. Chairman, counsel has
19 asked how we would try to reduce the number of people who
20 over-stay in the hospitals, and I think what we have done
21 is worthy of mention. A good medical staff organization
22 with discharge committees, whose duty it is to review
23 patients almost daily, if possible, which is a very onerous
24 duty, I will admit, in a large hospital; but, nevertheless,
25 I think this is the crux of the whole matter, and the
26 thing that has to be encouraged and developed more and
27 more -- if we have adequate discharge committees in all
28 hospitals to review all patients and suggest to doctors
29 that this patient is ready for discharge.
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4 This presupposes that all of those ready for discharge
5 have some place to go and this is what we mean. I think
6 the crux of the matter is a well-organized staff with a
7 good discharge committee.

8 MR. HALL: Does the administrative staff
9 of the hospital play any part in controlling apart from
10 discharge?

11 MR. ROSENFELD: I would say the administra-
12 tive staff act as an incentive and a catalyst in this
13 area so that the hospital itself is not in the practice
14 of medicine nor can the hospital discharge a patient.
15 It is the doctor who makes this decision. We endeavour
16 to assist the doctor in reaching this point at the
17 earliest point he can by outlining to him our social
18 service department of the community where a patient could
19 go, the assistance he could get and other things to
20 increase or decrease the length of stay. However it is
21 the doctor who makes the discharge. We can only bring to
22 him those things in which the community has to assist in
23 the discharge of a patient.

24 MR. HALL: Are you able to give any sugges-
25 tion as to any type of control that could be retained in
26 the hospital insurance or medical care plan which could
27 reduce the amount of over-stay?

28 DR. L'HEUREUX: By legislation or what?

29 MR. ROSENFELD: I think the important
30 thing is in the area of education and persuasion and
31 the development of a standard on a voluntary basis by
32 the community at large and an understanding of the problem.
33 By legislation one would have to also write in the



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3 question of under-stay, if one were to write in the
4 question of over-stay in hospital and this would tie,
5 I would feel, the hands of the medical profession to a
6 very large extent.

7 DR. L'HEUREUX: I think if this was written
8 into the legislation it would necessitate the definition
9 of "over-stay" and this is a most difficult thing
10 because we get involved into what is abuse of hospital
11 beds and what is not abuse. It is very, very difficult
12 to put down in our minds, let alone in a legal document
13 because if we have a very strict interpretation of only
14 those who need all the facilities of an acute general
15 hospital as those legally admitted to a hospital, we
16 would automatically say "Take away all the maternity
17 cases because they do not need to be here". This can get
18 involved in writing these things out. That is why in
19 medical staff by-laws we do not try to write out in legal
20 form "over-stay" or "under-stay" or what is a normal stay.
21 We leave it up to the interpretation of the conditions to
22 which it is applying.

23 COMMISSIONER VAN WART: May I ask, as
24 administrators have you any responsibility in this over-
25 utilization in seeing that your x-ray departments or
26 pathological departments and nursing services use the
27 minimum amount of time to shorten the stay in the hospital
28 of these people?

29 DR. BRADLEY: Yes, I noted this when
30 Mr. Rosenfeld was speaking. Unquestionably the general
services of the hospital, the prognosis and the scheduling
in the operating room and the diagnostic procedures, the

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5 a general responsibility of the administration, there is
6 no question.

7 COMMISSIONER VAN WART: It may be quite a
8 factor in length of stay in the hospital, might it not?

9 DR. BRADLEY: I find it hard to evaluate.
10 I have discussed this with some of the more learned
11 internists around our place and some of them believe in
12 wide sweeping appointments in which they hit a patient
13 with eight tests the first day trusting they can get
14 definitive information the first day. Other more conser-
15 vative ones will take four tests on the first day and
16 two the next and two the next. What is the better prac-
17 tice, the better utilization? Again you must rely on the
18 approach, to a great degree, on the quality of the medical
19 staff. However, the general premise you advance has found
20 that administration have the responsibility to render
21 these things available.

22 COMMISSIONER VAN WART: Has the weekend lag
23 any effect at all?

24 DR. BRADLEY: We with the plan here have
25 been trying to determine this and I do not think we can
26 do it one way or the other. The usual position taken
27 in approaching this is, as we have the expensive facili-
28 ties, if we can use it seven days a week this is a way to
29 do it. When you get into the economics of it, however,
30 you find in the supply of staff you are not simply
opening the operating room for three hours on Saturday
morning but you are then establishing intensive nursing



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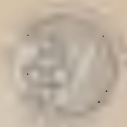
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4 care for Sunday and Monday. If you are doing it on
5 Friday and slowing up Saturday you could give some
6 respite to your nurses. The same goes with lab. and the
7 same with x-ray. One limiting factor, of course, is
8 that there has been a shortage of certified people to
9 make these available seven days a week. I think you must
10 also bring in the mores of our community. We are
11 establishing the week in Canada; we still have in this
12 community a fine respectful Sunday and I hope we retain
13 it and this cannot be done if we work seven days a week
14 at the hospital. I would say in a tangible way an
15 institution which provides so much personal service
16 requires a lag in order to wind up its batteries. To
17 put the staff nurses and all the ancillaries to work
18 seven days a week is a pretty heavy demand.

19 COMMISSIONER VAN WART: The community
20 have Saturday, so to speak, free and hospital service
21 available on Saturday for them would be an asset as far
22 as they are concerned.

23 MR. ROSENFELD: Services are available,
24 there is never a complete lag, just an effort to reduce
25 the peak loads that we are scared of on Saturdays and
26 Sundays and from them we have established the pattern of
27 a seven-day cycle. You meet with certain community
28 responsibilities and meet particularly with responsibilities
29 during the month of April to October when the weekends
30 seem to have a little bit more importance than in other
periods of the year. Unfortunately, this is one of the
social factors that have to be recognized in this parti-
cular area.



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COMMUNITY AND HOSPITAL: The community
have Saturday, so to speak, home and hospital service
available on Saturday for them would be an asset as far
as they are concerned.
MR. HOLMSTED: Services are available,
there is never a complete lag, just an effort to reduce
the peak loads that we are faced with on Saturday and
Sunday and from then we have established the pattern of
a seven-day cycle. You meet with certain community
responsibilities and meet particularly with responsibility
during the month of April to October when the weekends
seem to have a little bit more importance than in other
periods of the year. Unfortunately, this is one of the
social factors that have to be recognized in this partic-
ular area.



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4 COMMISSIONER VAN WART: Of course, now
you have a tremendous peak on Mondays?

5 MR. ROSENFELD: We try to meet that peak
6 on Monday and in many instances we have opened our labs
7 on Sunday nights to meet this peak with a Sunday admission
8 and working on Monday. We can do many of the preliminary
9 tests on Sunday night so these patients won't be held up
10 in pre-operational tests being done. I think all hospi-
11 tals are running a 24-hour service but they hope the
peaks in this service are Monday to Friday.

12 COMMISSIONER VAN WART: I want to bring
13 this out; in the question of utilization there is a
14 question of longer stay in the hospital by virtue of
15 this practice.

16 DR. BRADLEY: I have in two situations
17 tried to come to an answer on this and I must say that I
18 cannot. There seems to be a cycle about times and length
19 of illness. This may follow the practice of the doctor
20 in establishing the length of stay but I can't see any
21 advantage or disadvantage one way or the other to drive
22 strongly administratively and say "We must operate seven
23 days a week". I do not think the gain in better use of
24 a capital asset would offset some of the disadvantages
25 we now have, asking the staff to work seven days a week,
26 24 hours a day and to take night shifts and so on. We
27 have enough trouble keeping them out of the department
stores and the insurance buildings in nice clean surroun-
dings as it is now without making it worse.

28 COMMISSIONER VAN WART: Well, of course,
29 the staff would be staggered?
30

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the staff would be staggered?



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3 MR. ROSENFELD: Staggered and increased.

4 THE CHAIRMAN: Is there any limitation,
5 time limitation, on discharges in one part of the day
6 as from another?

7 MR. ROSENFELD: I think each hospital has
8 its own internal standards. We hope to have a patient
9 discharged as close to noon as we can so the room can be
10 refreshed and a new patient admitted between 2 o'clock
11 and 4 o'clock in the afternoon so we can start with
12 ancillary services, diagnostic services and care for the
13 particular cases. In certain cases it is very difficult
14 for a working man who is coming in for a minor procedure,
15 he does not want to leave his work at noon, he prefers
16 to come at 6 o'clock. We exert every administrative
17 pressure we can to have all these patients come in at
18 2 o'clock and have the people leaving at noon. The
19 converse is true, the patient being discharged does not
20 want her husband to leave his work at noon, she would
21 rather have him pick her up at 6 o'clock. On many
22 occasions we have asked patients to go to the waiting
23 room until they are picked up because their doctor has
24 discharged them.

25 DR. L'HEUREUX: The only other factor is
26 the idea in some hospitals such as ours where we are
27 trying to have the doctor notify us of the discharge
28 24 hours ahead of time so that we can advise the patient
29 so that the husband can be advised by the wife and every-
30 thing will be ready the next morning. In this way we
31 feel we are saving quite a few half-days. This is not
32 possible in all cases, of course.

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3 MR. HALL: I have no further questions.

4 COMMISSIONER BALTZAN: Mr. Rosenfeld,
5 would you please elaborate on the last line of the first
6 paragraph on page 5 which I read:

7 "...the introduction and endorsement of
8 minimum rather than maximum standards".

9 MR. ROSENFELD: This deals with recommen-
10 dations dealing with the standards of hospital operation
11 and while it has not been too overt, on certain occasions
12 we have felt there has been a tendency for standards to
13 be enunciated in terms of maximum and minimums simul-
14 taneously that this shall be it and leaves no opportunity
15 for individual deviation from these particular standards
16 in the areas of hospital operation. This is something
17 that we are quite scared of that there should be a maximum
18 placed without individual deviations. We say there shall
19 be a minimum but the maximum shall be in terms of the
20 individual needs of a particular hospital or the parti-
21 cular activities of a particular hospital.

22 COMMISSIONER BALTZAN: In other words,
23 the word "minimum" is not synonymous with lower standards?

24 MR. ROSENFELD: No, sir.

25 COMMISSIONER BALTZAN: That is what I
26 wanted to know.

27 MR. ROSENFELD: These may be acceptable
28 standards in leaving maximum to be established on an
29 individual basis.

30 COMMISSIONER BALTZAN: Have you any compa-
rative figures on the length of stay in the small community
hospitals versus the length of stay in the larger city

MR. WALL: I have no further questions.

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COMMISSIONER BALTAN: Have you any com-

relative to the standards of the hospital?

COMMISSIONER BALTAN: Yes, sir.



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3 hospitals?

4 MR. ROSENFELD: Yes sir, I have. I can
5 give you this information in comparison with the year
6 1948. The average length of stay in the year 1959 for
7 hospitals of 1 to 20 beds in Manitoba was 6.9 days; 25
8 to 99 beds, 7.4 days; 100 to 199 beds, 9.7 days; 200 to
9 299 beds, 8 days; 300 to 499 beds, 9.3 days; 500 beds-
10 plus, 11.3 days. The average was 9 days. I would like
11 to make the comment that in the larger hospitals there
12 is perhaps a more intensive type of case being treated,
13 a more difficult type of case being treated, than there
14 is in some of the smaller hospitals and this accounts to
15 a large degree for the length of stay.

16 DR. BRADLEY: I think the comprehensiveness
17 of the service has to be considered here. The hospital in
18 which Dr. L'Abreux and I work has a wide range of services,
19 among them being a psychiatric department. As you know,
20 the length of stay in the psychiatric hospital runs to
21 22 days and this can draw that average up remarkably.
22 The same should be said of the treatment of a patient
23 with cancer who, by and large, requires more days of
24 stay. The study to which we referred earlier, the Michi-
25 gan study, also indicated in teaching institutions some-
26 thing like 2 days pre-selective stay was added so the
27 length of stay was 2 days longer than in the case of other
28 hospitals. In other words, more intensive investigation,
29 more complete staff, sensitivity to more possibilities of
30 disease, the impact on the individual, his physiology and
chemistry being better understood. You can understand
that this would likely take a longer period of time.



hospitals?

MR. ROSS: Yes sir, I have. I can

give you this information in comparison with the year 1948. The average length of stay in the year 1948 for hospitals of 1 to 20 beds in Manitoba was 8.3 days; 25 to 39 beds, 7.4 days; 100 to 199 beds, 6.7 days; 200 to 299 beds, 6 days; 300 to 499 beds, 5.3 days; 500 beds and over, 4.3 days. The average was 6 days. I would like to make the comment that in the larger hospitals there is perhaps a more intensive type of case being treated, a more difficult type of case being treated, than there is in some of the smaller hospitals and this accounts to a large degree for the length of stay.

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You can relate this both to teaching, research and to more elaborate facilities. I think probably these figures would be indicative of the whole of the country.

COMMISSIONER BALTZAN: You also included, I think, the accommodation for the student time in learning about the cases?

DR. BRADLEY: Indeed, and I think this must involve the distaff side of your panel, in schools of nursing, the time required for the training of nurses.

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4 COMMISSIONER BALTZAN: And incidentally
5 too, in a teaching hospital the cost is greater than in
6 a non-teaching hospital, due to this extra preparation
7 for the benefit of the teachers or of the students?

8 DR. BRADLEY: There is no question of
9 this. I think you must add to this, however, the logical
10 and obvious fact that to your teaching in a larger
11 hospital comes the more complex case, the case that has
12 been referred by the physician in the smaller community,
13 knowing that it is complex, or that complications have
14 arisen, that require the facilities of the larger hospital.

15 COMMISSIONER BALTZAN: There is no provi-
16 sion in terms of finance for the teaching hospitals
17 because of this extra load of cost that they are carrying?

18 DR. BRADLEY: Whether or not to present
19 this aspect of it was considered by my hospital, and
20 perhaps it is going to be presented by Dr. L'Heureux,
21 of St. Boniface. In my own institution the understanding
22 of the plan here of greater demands for education and
23 research have been understood and in the present system
24 of financing our needs are being met. However, I think
25 looking at the national scene, there will be representa-
26 tions by other bodies on the need of established sources
27 of funds for research and for education, and unquestionably
28 as the accounting side of the phase has its bearing on
29 health services, they will wish to have clear ledger
30 sheets, and perhaps this will be examined with some fore-
sight now.

31 THE CHAIRMAN: Do you discern, gentlemen,
32 any change in the pattern of length of stay?



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4 MR. ROSENFELD: I believe, sir, there
5 has been an increase in the length of stay, if you are
6 referring this to a base of 1958 in Manitoba.

7 THE CHAIRMAN: Yes, as distinct over
8 another period?

9 MR. ROSENFELD: Yes, I think there has
10 been an increase in the length of stay, but I think this
11 length of stay may be reaching an optimum, if you will,
12 or a maximum, because there was a backlog of cases,
13 particularly in the elderly group, who were not covered
14 by hospitalization prior to 1958, who were admitted to
15 hospital, and therefore their average length of stay
16 was perhaps longer than heretofore. Also in many cases
17 this age group, sir, are now being admitted to hospitals,
18 who because of other reasons before were not being
19 admitted to hospitals, and this has tended to increase
20 the length of the stay, but I know in our institution
21 we are very seriously looking at this and expecting to
22 some extent a levelling off, if we don't introduce new
23 services which will have a bearing upon this length of
24 stay.

25 THE CHAIRMAN: We may then expect to get
26 perhaps a different answer in a place where the hospitali-
27 zation has been in effect since 1948?

28 MR. ROSENFELD: Yes sir.

29 DR. BRADLEY: I can make available, sir,
30 to your research staff the statistics of a single insti-
tution, and I am pleased that Mr. Rosenfeld drew attention
to the impact of an aging population, because there is
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3 not been due entirely to the comprehensiveness of our
4 hospital care program. It has been due to progress,
5 changing community attitudes, and a lot of other things,
6 among them being aging population, but the statistics
7 of the hospital that I represent are rather interesting.
8 Commencing from 1951, coming forward, 12.4, 12.1, 11.6,
9 11.8, 11.6, 11.6, 11.3, that was 1957, 11.6, 12, 12.6
10 last year and this year I understand from our preliminary
11 figures, 12.6, so in relationship to a curve, this has
12 been pretty much of a plateau.

13 THE CHAIRMAN: What would be this community
14 mores you have been speaking of? Is Manitoba much
15 different than, say, the rest of western Canada, or
16 Canada as a whole? For instance, we heard in Newfoundland
17 that the average stay in the maternity case was three-and-
18 a-half days, which seemed to be a remarkably short time
19 compared with the figures for Manitoba. I don't know
20 what your figure might be.

21 DR. L'HEUREUX: It varies from hospital
22 to hospital, but I would say anyway from four-and-a-half
23 to six days.

24 COMMISSIONER McCUTCHEON: Which is much
25 shorter than it used to be, is it not?

26 DR. BRADLEY: Oh, yes.

27 COMMISSIONER McCUTCHEON: In other words,
28 that is a change in community opinion and medical opinion?

29 DR. BRADLEY: Yes.

30 DR. L'HEUREUX: The average stay in
hospital has gradually been coming down. We expected
after the introduction of the M.H.S.P. a sharp rise, I



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3 think, because of the ---

4 THE CHAIRMAN: This backlog?

5 DR. L'HEUREUX: The availability and the
6 backlog, and the publicity of this thing, and there was
7 a rise for about one year, but the doctors soon counter-
8 acted this I think on their own, because they couldn't
9 get as many patients in, and they began working on it,
10 and it has come down, and in our own hospital it has
11 come down and it is lower than ever at the moment.

12 MR. ROSENFELD: I have here a table
13 entitled The Average Length of Stay for all hospitals,
14 I believe. The stays are from 1953, 6.55, 1958, 6.1;
15 1959, 6.3 or 6.5, and these are again broken down in
16 terms of size of hospital.

17 COMMISSIONER VAN WART: Have you the
18 figures for a small hospital around 50 beds?

19 MR. ROSENFELD: Yes sir, I may say this
20 comes from one of the most comprehensive reports on
21 sociology and public health care that the Dominion of
22 Canada has ever known, and it is with true pride that
23 we say that the Manitoba Hospital Survey Report has been
24 filed with this Commission.

25 COMMISSIONER VAN WART: The 50-bed
26 hospital?

27 MR. ROSENFELD: It is broken down to 25 to
28 99 beds. It is 6.3.

29 COMMISSIONER GIRARD: Mr. Chairman, I
30 would like to commend these three hospital administrators
on the tribute they have paid to the nursing profession
in this brief, to the extent of mentioning their services

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DR. L'HEUREUX: The availability and the backlog, and the publicity of this thing, and there was a rise for about one year, but the doctors soon counteracted this I think on their own, because they couldn't get as many patients in, and they began working on it, and it has come down, and in our own hospital it has come down and it is lower than ever at the moment.

MR. ROSEBLED: I have here a table entitled The Average Length of Stay for all hospitals, 1959, 6.3 or 6.5, and these are again broken down in terms of size of hospital.

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4 usually modest, and this is very touching for the nursing
5 profession to get this recognition from hospital admini-
6 strators.

7 I would like to ask a question of Dr.
8 Bradley. On page 2, paragraph 10, where it states:
9 "The Associated Hospitals of Manitoba believes that an
10 increase in public health nursing can reduce the need
11 for both acute general or convalescent hospital beds
12 required by the population".

13 We all know that we do need more public
14 health nurses if we are going to get into home care,
15 but home care cannot be dependent upon - home care cannot
16 depend only on public health nurses. We need homemakers.
17 We need social workers. We need physiotherapists, and
18 rehabilitation people. Dr. Bradley, can you tell us in
19 your experience of home care at the Winnipeg General
20 Hospital, what would be the ratio of the use of the
21 nurse in relation to these other para-medical workers?
22 How many visits would there be for instance where you
23 would use only the nurse?

24 DR. BRADLEY: Mr. Chairman, I think in a
25 home care program the two primary persons involved usually
26 are first the nurse, and secondly the doctor. I say
27 secondly the doctor, because we have found in a program
28 which has been operating for some three years now, that
29 if the selection of case has been good, if the family has
30 been prepared for the task, that the visits of a doctor
become longer, the time between them becomes longer, and
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We all know that we do need more public health nurses if we are going to get into home care, but home care cannot be dependent upon - home care cannot depend only on public health nurses. We need homemakers. We need social workers. We need physiotherapists and rehabilitation people. Dr. Bradley, can you tell us in your experience of home care at the Winnipeg General Hospital, what would be the ratio of the use of the nurse in relation to these other para-medical workers? How many visits would there be for instance where you would use only the nurse?

DR. BRADLEY: Mr. Chairman, I think in a home care program the two primary persons involved usually are first the nurse, and secondly the doctor. I say secondly the doctor, because we have found in a program which has been operating for some three years now, that if the selection of case has been good, if the family has been prepared for the task, that the visits of a doctor become longer, the time between them becomes longer, and particularly as the experience of the nurse in reporting,



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3 as she is sensitive to the needs of the family, as her
4 skill becomes greater with the family. I have not
5 precise statistics on the number of nursing visits,
6 although I am sure this could be made available to you.

7 Perhaps I should modify this. Unquestio-
8 nably the homemaker part of it is most important, and,
9 as represented earlier, the greatest need we have found
10 is for the organization of a more available homemaker
11 service to keep these people at home, to support the
12 nurse who comes in as a specialist in her particular
field.

13 COMMISSIONER GIRARD: Would you say that
14 the greatest number of persons involved in a home care
15 program after the nurse would be the homemakers?

16 DR. BRADLEY: I would correct it to the
17 extent that I think the homemaker is probably first
involved, then the nurses.

18 COMMISSIONER GIRARD: So in any home care
19 program that anyone would envisage, we would have to
20 take cognizance that this would have to be concurrent
21 with the homemaker service, if it didn't exist ----

22 DR. BRADLEY: Definitely.

23 COMMISSIONER GIRARD: How do you feel
24 about the referral programs where you cannot, as a
25 second best to a home care program for liberating beds
in the hospital?

26 DR. BRADLEY: It is the best of the second
27 level in some communities for one reason or another it is
28 it is full, I think. The usual agency, at
29 least in western Canada, is the V.O.N., where it has
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COMMISSIONER GIRARD: How do you feel about the referral programs where you cannot, as a second best to a home care program for liberating beds in the hospital?

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3 established itself with the medical profession particu-
4 larly and has been invited and engaged within the hospital
5 to make its services available. There you find it very
6 effective.

7 COMMISSIONER GIRARD: Do you feel that it
8 is worthwhile for a hospital to pay, let us say, a
9 salary to one nurse in a referral system, that the
10 hospital gains a lot more than the outlay of money in
11 paying the services of one nurse to do that referral
12 system from the hospital?

13 DR. BRADLEY: I would say yes, with the
14 expectation that the results may be disappointing for
15 several years, but that in the general attitude of the
16 shift from the home to the hospital, in changing the
17 general community outlook, this might well be worthwhile
18 as a long-term project. You might not get substantial
19 results on paper in the first two or three years of opera-
20 tion.

21 COMMISSIONER GIRARD: You do not have any
22 hospitals in Winnipeg with the referral system?

23 DR. BRADLEY: Yes, not with an organized
24 in-hospital referral centre, but when we say that most
25 hospitals are aware of the usefulness of the V.O.N. in
26 this field, and have this available, although again this
27 is probably not pressed upon family or physician to the
28 degree that might be needed.

29 COMMISSIONER GIRARD: Mr. Chairman, I
30 would also like to emphasize the statement made by Dr.
L'Heureux a few minutes ago about the discharge committee
in the hospital as a means to reducing the stay. I



established itself with the medical profession particularly and has been invited and engaged within the hospital to make its services available. There you find it very

COMMISSIONER GIRARD: Do you feel that it

is worthwhile for a hospital to pay, let us say, a

salary to one nurse in a referral system, that the

hospital gains a lot more than the outlay of money in

paying the services of one nurse to do that referral

system from the hospital?

DR. BRADLEY: I would say yes, with the

expectation that the results may be disappointing for

several years, but that in the general attitude of the

shift from the home to the hospital, in changing the

general community outlook, this might well be worthwhile

as a long-term project. You might not get substantial

results on paper in the first two or three years of opera-

tion.

COMMISSIONER GIRARD: You do not have any

hospitals in Winnipeg with the referral systems?

DR. BRADLEY: Yes, not with an organized

in-hospital referral centre, but when we say that most

hospitals are aware of the usefulness of the V.O.N. in

this field, and have this available, although again this

is probably not pressed upon family or physician to the

degree that might be needed.

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L'Honnoux a few minutes ago about the discharge committee

in the hospital as a means to reducing the stay. I



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4 believe that this is a very important committee, and I
5 know of hospitals where this committee does not exist,
6 where the nurses are doing this function to a certain
7 extent, and it does help to remind the doctor to a
8 certain extent that the patient might be able to go,
9 and if I wanted to seem facetious, I might also say that
10 having a couple of forms to fill in each week might help
11 also, because on the 30th day of the stay of a patient
12 in a hospital, the doctor has to fill in a form, and if
13 a nurse reminds the doctor on the 27th or the 28th day,
14 he is not going to fill that form. The patient is
15 usually discharged before, unless of course, there are
16 very serious reasons, but there are a great number of
17 patients who are discharged just because of that form
18 that has to be filled, so maybe if there were a greater
19 number of forms, perhaps in the second and third weeks ---

20 DR. BRADLEY: Perhaps of a red colour.

21 COMMISSIONER GIRARD: I just gave this in
22 because it might work to a certain extent.

23 DR. BRADLEY: Mr. Chairman, I don't expect
24 you expect us to take sides on this.

25 THE CHAIRMAN: We will umpire these
26 discussions in camera later on.

27 Now gentlemen, it is being suggested in
28 medical fields that the future treatment of mental illness
29 will be transferred from the mental hospital as we have
30 known it into the general hospital, a hospital such as
you represent here today. Would it be your opinion that
when that comes about that the statistics and the terms
of long or short stay will be affected, and which way?

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4 MR. ROSENFELD: I think, sir, that the
5 average length of stay in the hospital which will be
6 taking in a new program in terms of psychiatric care
7 will of course increase, because we know now that the
8 mental stay for an admission in an acute psychiatric
9 hospital runs longer than that of a general patient.
10 I think too, that in one of the institutions where I
11 had the privilege of working, we found that the availabi-
12 lity of this service has tended to decrease the length
13 of stay in other areas to some extent. I think much
14 more important is the availability of professional help
15 to these people in the institution. The provision of
16 the beds without intensive therapy in a general hospital
17 is not the answer. We must have that intensive therapy,
18 or otherwise we might find ourselves falling back to doing
19 in a general hospital what was done in the provincial
20 centres.

21 DR. BRADLEY: Mr. Chairman, undoubtedly
22 this will increase the length of stay, but I think you
23 know that the shift is going on at a pace, and we can
24 only expect it to go on at a greater pace. We don't
25 know the percentages of mental patients between general
26 and acute hospitals here. In the States the admissions
27 to acute general has exceeded the admissions to general
28 hospital. I think the community and society as a whole
29 must expect the increased cost of this intensive care.
30 The treatment of acute mental hospital cases now is the
same as acute medical or surgical, and I think this is
long overdue, and I think it is about time we did some-
thing sound in this field.

MR. ROBERTS: I think, sir, that the

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4 THE CHAIRMAN: We will have to recognize
5 it is going to cost us more money?

6 DR. BRADLEY: It is going to cost us a
7 great deal more money. It has been out behind the hedge
8 for so many years that the public is not prepared to
9 spend money on it.

10 COMMISSIONER BALTZAN: Has the incidence
11 of traumatized accident cases increased?

12 DR. BRADLEY: Very materially sir. I am
13 sure statistics are available from many sources, but
14 there is no question that the emergency department of a
15 hospital is busier, both in the traumatic cases, and to
16 use the phrase used by certain writers recently, it is
17 now in the larger centres particularly becoming a
18 personal emergency resource. People are coming to the
19 casualty department of the hospital for other than trau-
20 matic requirements. This, of course, is a problem in
21 other than large teaching hospitals. However, it is
22 the result of the community attitude, or image of the
23 hospital, and I think we can expect that hospitals will
24 be loaded in the years ahead with a greater than hospital
25 cost. They will be loaded with the medical care cost.
26 I think we might bring out as well in the distribution
27 of hospitals across a rural province like Manitoba, that
28 the hospitalization fund is being inflated in the distri-
29 bution of medical care. There is no question that the
30 location of many small hospitals, it is primarily to
take to that community and make available on a fairly
regular basis, medical attention, but as the books are
now made out this is charged to hospital care. This is

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4 not too well understood, and our confreres in government,
5 and those of us in the operating field, are often blamed
6 for these costs, whereas it is health costs, which
7 should not be directed to one spending group in the
8 field.

9 COMMISSIONER McCUTCHEON: Mr. Rosenfeld,
10 in your brief at page 3, paragraph 14, you refer to the
11 relief that the introduction of the hospital service
12 plan brought with respect to operating costs, and you
13 then go on to say, "There has not, however, been a
14 parallel gain in the availability of capital funds,
15 largely because of public misunderstanding". Would you
16 care to expand on that?

17 MR. ROSENFELD: Yes, sir; this is meant
18 to be that donations coming from the community to the
19 hospital have decreased to some extent after the intro-
20 duction of the Manitoba Hospital Services Plan, because
21 of the fact that the community at large feels to some
22 extent they are being taxed with the growth of this
23 hospital, and therefore, contributions in the sense of
24 the voluntary contribution are not required. We wish to
25 point out to you, sir, that this government accepted the
26 view of our own Association recognizing this fact and
27 has now stated that 20% new equity is required for the
28 growth of the hospital, and with our own province
29 guaranteeing or recommending the guaranteeing of bonds
30 beyond that period of time allows for the total cost of
the hospital to be expanded. So, new hospital growth
is on the basis of 20% new equity into that growth. We
feel this will serve to meet the lessening funds that



not too well understood, and our conferees in government, and those of us in the operating field, are often blamed for these costs, whereas it is health costs, which should not be directed to one spending group in the

in your brief at page 3, paragraph 14, you refer to the relief that the introduction of the hospital service plan brought with respect to operating costs, and you then go on to say, "There has not, however, been a parallel gain in the availability of capital funds, largely because of public misunderstanding". Would you care to expand on that?

MR. ROSENFELD: Yes, sir; this is meant

to be that donations coming from the community to the hospital have decreased to some extent since the introduction of the Manitoba Hospital Services Plan, because of the fact that the community at large feels to some extent they are being taxed with the growth of this hospital, and therefore, contributions in the sense of the voluntary contribution are not required. We wish to point out to you, sir, that this government accepted the view of our own Association recognizing this fact and has now stated that 20% new equity is required for the growth of the hospital, and with our own province guaranteeing or recommending the guaranteeing of bonds beyond that period of time allows for the total cost of the hospital to be expanded. So, new hospital growth is on the basis of 20% new equity into that growth. We



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4 will be coming to the hospital because of the people
5 saying that they are being taxed for hospitals and they
6 don't want to contribute to the growth. They say these
7 are government institutions and not quasi-government
8 institutions, and they don't want to make contributions.
9 Our Association has taken to the field in this particular
10 area and has re-stated to every community in the province
11 that the Government has not taken them over and that the
12 Government is paying the operating costs but not its
13 gross cost beyond its statutory grants in terms of
14 building grants for hospitals. Does that answer your
15 question?

16
17 COMMISSIONER McCUTCHEON: I thought that
18 was what you meant.

19
20 THE CHAIRMAN: Thank you very much,
21 gentlemen. You have accepted our invitation to come,
22 and we are very grateful to you for it.

23
24 Dr. L'Heureux, have you anything to add
25 in terms of the special item that appears in respect of
26 your name here?

27
28 DR. L'HEUREUX: Mr. Chairman, if you
29 will permit just a personal observation, and this will
30 terminate it: I do not see any way of stopping the
progressive increasing costs of hospitals throughout the
years, and I think all these methods we have discussed
are worth something but, personally, I think we have
to give back to the three parties involved some responsi-
bility if we are to keep this at a reasonable level.

31
32 I think we have to give back to the
33 patient himself some responsibility for the care of his



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3 own body, and the only responsibility he will usually
4 agree to observe in any way is some charge, and I think
5 this is worth considering; by the term "charge", I mean
6 a per diem charge to the patient.

7 I think we have to give back to the
8 hospital administration some incentive to operate economi-
9 cally. I think we have to give to the doctors, the third
10 party concerned, some incentive to operate economically
11 also in the hospitals to avoid unnecessary tests and
12 unnecessary lengths of stay, and so on.

13 I think, finally, in this way we could
14 determine whether this will get out of hand or will
15 remain at a reasonable level.

16 Other than this, Mr. Chairman, I have
17 nothing more to add on behalf of the General Hospital,
18 St. Boniface, Manitoba.

19 THE CHAIRMAN: Thank you very much.
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to reserve in any way as being charged, and I think this is worth considering; by the term "charge", I mean

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determine whether this will get out of hand or will

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Other than this, Mr. Chairman, I have

nothing more to add on behalf of the General Hospital,

St. Boniface, Manitoba.

THE CHAIRMAN: Thank you very much.



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4 THE CHAIRMAN: We will next have the
5 submission of the Canadian Mental Health Association,
6 Manitoba Division.

7 --- EXHIBIT NO. 71: Submission of the Canadian Mental
8 Health Association, Manitoba
9 Division.

10 SUBMISSION OF THE CANADIAN MENTAL HEALTH ASSOCIATION,

11 MANITOBA DIVISION

12 Appearances: Mrs. E. Grieve
13 Dr. M. Wright
14 Dr. Burch
15 Father Empson
16 Miss DesJardins

17 MISS DesJARDINS: I would like to start,
18 Mr. Chairman, by thanking you very warmly for giving us
19 this opportunity to meet with you, and by introducing
20 the members who are representing the Canadian Mental
21 Health Association. First, Mrs. Elizabeth Grieve, who
22 is a psychiatric nurse on the staff of the Canadian
23 Mental Health Association. She is a director of our
24 social rehabilitation programs. Dr. M. Wright is a
25 member of our Scientific Planning Committee, and is a
26 psychologist. Dr. Burch is a psychiatrist in private
27 practice and a member of our Scientific Planning Committee.
28 Father Empson is the Vice-President of our Division. I
29 am a social worker and executive director of the Division.

30 Our group felt it would be helpful to the
Commission if Father Empson very briefly reviewed some
of the background.

FATHER EMPSON: Mr. Chairman and members
of the Commission, I am rather nervous at this

THE CHAIRMAN: We will now have the

--- EXHIBIT NO. 11: Substitution of the Canadian Mental
Health Association, Manitoba

Appearance: Mrs. A. J. Smith

Dr. Burch
Father Bapson
Miss Beaton

MISS BEATON: I would like to start.

Mr. Chairman, by thanking you very much for giving us

this opportunity to meet with you, and by introducing

the members who are representing the Canadian Mental

Health Association. First, Mrs. Elizabeth Bapson, who

is a psychiatric nurse on the staff of the Canadian

Mental Health Association. She is a member of our

social rehabilitation program. Mr. Bapson is a

member of our Scientific Planning Committee, and is a

psychologist. Dr. Burch is a psychiatrist in private

practice and a member of our Scientific Planning Committee.

Father Bapson is the Vice-President of our Division. I

am a social worker and executive director of the Division.

Our group felt it would be helpful to the

of the background.

FATHER BAPSON: Mr. Chairman and members



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3 presentation; I am not used to this kind of an audience,
4 and my apprehension is a little great. I represent the
5 President of the Canadian Mental Health Association, the
6 Manitoba Division. He was recently named Queen's Counsel
7 and Magistrate of the Winnipeg Police Court. He is also
8 the national President of the Canadian Mental Health
9 Association and is now on official business in the east
10 for the Association. He has had the pleasure of meeting
11 you before upon the presentation of a brief in the name
12 of the national Association.

13 Our Manitoba section, though modest, is
14 quite active and comprises a Board of 24 members. They
15 come from all walks of life. The Scientific Planning
16 Committee is what we call the expert group and comprises
17 psychologists, psychiatrists, and also social workers.
18 We get from them the information we need to try to do
19 the work established by the Association to acquaint the
20 public with the problem of mental health, and through
21 the organization of different branches throughout the
22 province to make the work of the mental health something
23 of concern for the whole of the province -- all of the
24 people -- and to make the work easier. The branches
25 are established for Brandon, Portage, Flin Flon and
26 Selkirk, and the most important work of the branch is to
27 make the public sympathetic to the mental patients both
28 in the hospital and outside the hospital, and also to
29 try to bring before the public the work of the staff
30 in the different hospitals.

31 The Association's accomplishments are
32 many and varied: to cite a few -- and you will find them

presentation; I am not used to this kind of an audience.

President of the Canadian Mental Health Association, the
Mantoba Division. He was recently named Jones's General
and Magistrate of the Winnipeg Police Court. He is also
the national President of the International Mental Health
Association and is now on official business in the west.
for the Association. He has been a frequent of meeting;
you before upon the Committee for a while in the name
of the national Association.

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quite active and comprises a group of the members. They
come from all walks of life. The Scientific Committee
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psychologists, psychiatrists, and also social workers.
We get from them the information we need to try to do
the work established by the Association to represent the
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of concern for the whole of the province -- all or the
people -- and to make the work easier. The branches
are established for Brandon, Portage, Winnipeg, and
Selkirk, and the most important work of the branch is to
make the public sympathetic to the mental patients both
in the hospital and outside the hospital, and also to
try to bring before the public the work of the staff
in the different hospitals.

Many are the people who are interested in the work of the



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3 listed in the brief -- we are quite pleased and proud
4 of the Open Door Club which receives both the ex-patients
5 and actual patients of the hospital to try and help them
6 adjust themselves to life outside the hospital. The
7 volunteers, approximately 500 of them, help also the
8 patient to adjust himself to life by serving meals to
9 him and also by helping even in window shopping and
10 dancing. The Christmas gift prize, I think, is really
11 worthwhile in this province, where a gift is provided
12 for every patient in the hospital.

13 The group is deeply interested in the
14 problem of mental health and will make these suggestions
15 rather humbly after we have heard the different experts
16 in the other field. We do hope you will take them as
17 such and consider them carefully and that we will have
18 been some help in this field in the work of this Commis-
19 sion in trying to make the mental health problem better
20 understood by all, especially by the ordinary layman,
21 as I am. Thank you.

22 THE CHAIRMAN: Thank you Dr. Empson.

23 MISS DesJARDINS: Mr. Chairman, we thought
24 it would be helpful for the Commission in the understand-
25 ing of our brief to hear what Father Empson had to say
26 about our Association, because we feel our brief, coming
27 after briefs presented by experts in the field of mental
28 health, will very much reflect the opinion of lay people.
29 We do have advisors in the various fields of interest to
30 mental health, but we certainly do represent very largely
a lay opinion, and we who have been working with the
Association for six years in Manitoba feel very certain

listed in the brief -- we are quite pleased and proud of the Open Door Club which receives both the appreciation and actual patients of the hospital to try and help them adjust themselves to life outside the hospital. The volunteers, approximately 100 of them, help also the patient to adjust himself to life by serving meals to him and also by helping even to window shopping and dancing. The Christmas gift drive, I think, is really worthwhile in this respect, where a gift is provided for every patient in the hospital.

The group is deeply interested in the problem of mental health and will make these suggestions rather humbly after we have seen the different experience in the other field. We do hope you will find them as such and consider them carefully and that we will have seen some help in this field in the work of the hospital in trying to make the mental health problem better understood by all, especially by the ordinary layman, as I am, thank you.

THE CHAIRMAN: Thank you, Dr. Hanson.

MISS McLEOD: Dr. Chairman, we thought it would be helpful for the Commission in the understanding of our brief to hear what Dr. Hanson had to say about our Association, because we feel our help, coming

mental health, but we certainly do represent very largely
relation for six years in Manitoba feel very certain



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3 that now more than ever before we recognize a real readi-
4 ness for changes in the field of mental health in our
5 province. We feel that the 5,000 members who belong to
6 our Association who are taking an active part in the
7 work of our Association do represent this changing in
8 attitude, this interest, this willingness to do something
9 about the problem. We have stated in our brief that we
10 have 5,000 members, but I would like to enlarge on this
11 very briefly: while we say 5,000, in reality we have
12 many more than 5,000 people who are members of the
13 Association because some of these memberships which are
14 counted as one member may represent a women's institute
15 who has given us \$25, a group of employees who perhaps
16 has given us \$100 towards the work of our Association.
17 We also have 500 very active members who work as volun-
18 teers throughout the province with our Association.

18 We would like to add to the background
19 information which is contained on page 1 of our brief,
20 in the introduction where we explain how we set about to
21 prepare this brief, we would like to add information
22 related to a previous brief: I think it was about 1957,
23 the Flin Flon branch of our Association became part of
24 the Division, and it was first to make a study of
25 community resources. It was a very good study and I
26 think it brought out with a great deal of emphasis that
27 there were absolutely no mental health facilities in
28 Flin Flon or in that district.

29 Next, our Brandon branch became interested
30 and carried out a study in this field, and in 1959 the
whole division made a study of facilities in this field

before we recognized a real need in our field of mental health in our province. We feel that the 5,000 members who belong to our Association who are taking an active part in the work of the Association do represent this category in

about the problem. We have stated in our paper that we have 5,000 members, but I would like to enlarge on this very briefly: what we are 5,000, in reality we have many more than 5,000 people. In the ranks of the Association because some of these members which are counted as one member may represent a woman's institute who has given us \$25, a group of employees who perhaps has given us \$100 towards the work of our Association. We also have 500 very active members who work as volunteers throughout the province with our Association. We would like to add to the background

related to a previous brief: I think it was about 1917, the Film Film branch of our Association became part of the Division, and it was first to make a study of community resources. It was a very good study and I think it brought out with a great deal of emphasis that there were absolutely no mental health facilities in Film Film in that district.

Next, our Brandon branch became interested and carried out a study in this field, and in 1928 the



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3 in Manitoba, and followed this by a brief which was
4 presented to the Government of Manitoba in January 1960.

5 The Government of Manitoba accepted our
6 brief, accepting it as a long-range plan. We have been
7 very much interested in what was happening or steps
8 taken to implement some of the recommendations, and
9 particularly concerned about one area, the area of person-
10 nel, and for that reason we have come prepared this after-
11 noon with some additional information regarding personnel.

12 We have tried in the study which preceded
13 the presentation of this brief to have a look at the
14 whole of our problems and its services and lack of
15 services in the field of mental health. We are trying
16 to give you a broad rather than a deep picture. We have
17 given you this picture in details in our brief, but I
18 think to summarize this very, very briefly we should say
19 that services to the mentally ill in our province may be
20 obtained only in three areas: in Greater Winnipeg; in
21 Brandon; and in Selkirk. Services for the mentally
22 defective, in metro Winnipeg and Portage. Metro Winnipeg
23 has a population of 467,000 people; Brandon, which is
24 situated 129 miles from Winnipeg, a population of some
25 28,000; and Selkirk, situated 23 miles from Greater
26 Winnipeg, a little over 8,000. The population of Mani-
27 toba is 906,000, and Manitoba covers 251 square miles.
28 I think if we look very briefly at the services that
29 are available in this field in Manitoba, the picture
30 speaks for itself very eloquently in showing a picture of
inadequacy, and therefore because we believe in the
following basic principles we have made some recommendations

presented to the Government of Manitoba in January 1960.

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given you this picture in detail in our brief, but I

think to summarize this very, very briefly we should say

that services to the mentally ill in our province may be

obtained only in three areas: in Greater Winnipeg; in

Brandon; and in Selkirk. Services for the mentally

defective, in Metro Winnipeg and Portage. Metro Winnipeg

has a population of 437,000 people; Brandon, which is

situated 125 miles from Winnipeg, a population of some

28,000; and Selkirk, situated 23 miles from Greater

Winnipeg, a little over 8,000. The population of Mani-

toba is 906,000, and Manitoba covers 251 square miles.

I think if we look very briefly at the services that

are available in this field in Manitoba, the picture

speaks for itself very eloquently in showing a picture of

inadequacy, and therefore because we believe in the



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3 which we hope will be of interest to the Commission.

4 We believe that psychiatry is a medical
5 specialty which should be integrated with the rest of
6 medicine. We feel by this the patient would benefit by
7 being brought in from the isolated mental hospital to
8 the general hospital, and we feel that bringing in the
9 psychiatrist -- and, of course, we should add the psycholo-
10 gist and the social worker -- into the general hospital,
11 we would be also doing something which would be of bene-
12 fit to the other patients.

13 We believe that mental health services
14 should be orientated to the community. The patient's
15 illness begins in the community. He may or may not be
16 hospitalized during his illness, and if he is hospitalized
17 he probably will need some follow-up care when he returns
18 from the hospital. Therefore, we feel that mental health
19 services available to people in the community should be
20 prevention, diagnostic, treatment, rehabilitation, consul-
21 tation with agencies, and public education.

22 We believe that mental health services
23 should be co-ordinated and integrated, and we feel this
24 would prevent both duplication and gaps.

25 We believe that these services should be
26 decentralized and they should be on regional and local
27 planning, and we feel this is essential to the provision
28 of adequate mental health services.

29 We feel care and treatment should be
30 provided as close to the home of the patient as possible.

We believe that decentralization and
regional and local planning would give more responsibility

which we hope will be of interest to the Commission.
We believe that psychiatry is a medical
specialty which should be integrated with the rest of
medicine. We feel by this the patient would benefit by
being brought in from the isolated mental hospital to
the general hospital, and we feel that bringing in the
psychiatrist -- and, of course, we should add the psycholo-
gist and the social worker -- into the general hospital,
we would be also doing something which would be of bene-
fit to the other patients.

We believe that mental health services
should be oriented to the community. The patient's
illness begins in the community. It may or may not be
hospitalized during his illness, and if he is hospitalized
he probably will need some follow-up care when he returns
from the hospital. Therefore, we feel that mental health
services available to people in the community should be
prevention, diagnosis, treatment, rehabilitation, coordina-
tion with agencies, and public education.

We believe that mental health services
should be co-ordinated and integrated, and we feel this
would prevent both duplication and gaps.

We believe that these services should be
decentralized and they should be on regional and local
planning, and we feel this is essential to the provision
of adequate mental health services.

We feel care and treatment should be
provided as close to the home of the patient as possible.

We believe that decentralization and



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3 and would result in more involvement of a community.

4 We also believe that continuity of care
5 is an important factor in treatment. The patient
6 should be looked after by the same treatment scheme
7 throughout his illness and, of course, this will only be
8 possible if there is regionalization and integration of
9 these services.

10 DR. BURCH: Mr. Chairman, in keeping with
11 these principles, as stated by Miss DesJardins, the
12 mental health services have made some recommendations
13 that more or less parallel the recommendations that you
14 heard on Tuesday by the Manitoba Psychiatric Association.
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and we have been very successful in our work.

We also believe that continuity of care

is an important factor in treatment. The patient

should be looked after by the same treatment agency

throughout his illness and, of course, this will only be

possible if there is regionalization and integration of

services.

DR. BURCH: Mr. Chairman, in keeping with

these principles, as stated by Miss Hastings, the

following are the principles which we have adopted:

that more or less parallel the recommendations that you

heard on Tuesday by the Manitoba Paralytic Association.



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4 In some ways the recommendations in our brief are
5 perhaps in somewhat more detail and some ways more
6 expensive. For instance, we feel that, first of all,
7 because of the lack of overall planning in the psychiatric
8 services that are developing in this province that a
9 director of mental health services should be appointed
10 to advise the Minister, to advise the regional committees
11 which we hope will be set up in the future and to carry
12 out the activities throughout the province. We feel it
13 is in keeping with the regional aspect of new developments
14 that small psychiatric facilities should be set up in
15 different regions of the province; built mainly in conjunc-
16 tion with the general hospital facilities that already
17 exist. These hospital facilities would not be the end of
18 the plan, it would merely be centres around which the
19 psychiatric team - around which the total community
20 service could revolve. We feel too in keeping with the
21 social aspect that psychiatry is taking that these
22 local regions should not be directed only by professional
23 people but that Boards comprising both professional and
24 lay people should direct and co-ordinate and encourage
25 these community services into the region in which they
26 serve. These activities, other than hospitals and
27 acute treatment services would include school work,
28 advice to school boards, court work, rehabilitation work
29 and many other general activities that Miss DesJardins
30 mentioned. We feel too that there are many other hiatuses
in the psychiatric services in this province even in
urban areas such as Winnipeg where the children's services
are only beginning to be met and that hospital facilities

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4 similar to the ones advised by the Psychiatric Association
5 should be built in the Winnipeg area.

6 With regard to the investigation of court
7 cases, delinquents, community interest has been developing
8 in this area over recent years. There has been no
9 planning in order to serve these needs which the community
10 feels is necessary and I am sure will accept.

11 Those, I think, are the broad needs that
12 we feel should be met here. The biggest difficulties,
13 I think, in the development of these plans is, first,
14 an overall planning which I think the Government should
15 interest itself in more than it has perhaps in the past.
16 Money, of course, is important. But, most of all, I
17 think in keeping with all psychiatric service in this
18 country is the need for trained personnel. As the
19 Psychiatric Association has told you on Tuesday, we are
20 very, very short of trained people here so the filling
21 of these needs of trained personnel is not easy. The
22 University has started recently on a training program
23 for psychiatric specialists. The training of other para-
24 psychiatric personnel, ancillary people like social
25 service workers and psychologists is very much below the
26 demand that is and will be required. We feel that this
27 is perhaps our greatest need together with some overall
28 plan of utilizing their services when they can be
29 obtained.

30 That, I think, is the picture as we see
it and the needs that should be met. Dr. Morgan Wright
I think has been interesting himself in the development
of training programs for ancillary personnel and I think

similar to the ones advised by the Psychiatric Association
should be built in the Winnipeg area.

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it and the needs that should be met. Dr. Morgan Wright
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of training programs for ancillary personnel and I think



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3 will describe to the Commission what he feels should be
4 done in this regard.

5 THE CHAIRMAN: Thank you very much, Dr.
6 Burch.

7 DR. WRIGHT: Mr. Chairman, I would limit
8 my remarks pretty well to psychology, which is a very
9 small aspect of the report in terms of the number of
10 paragraphs devoted to it. However, in general, some of
11 the remarks I have to make I think will cover all the
12 para-medical personnel and although, again, not much of
13 this particular report is devoted to this, I think
14 following Dr. Burch's comments this is perhaps the most
15 pressing problem and in some ways perhaps the most diffi-
16 cult problem to solve.

17 In other words, were we to have the money
18 to follow through on the plans to establish some of the
19 facilities that are outlined in sort of a general way,
20 I think this should be done, at least we should set up
21 the physical facilities and could probably get the
22 co-operation and support of the community but to provide
23 the necessary personnel would be a very different matter
24 altogether.

25 To give you an idea of the problem in the
26 three largest institutions in Manitoba, these are the
27 Brandon, Portage and Selkirk institutions, there are to
28 my knowledge a total of one psychologist and a less than
29 one trained psychologist. The reasons for this are not
30 altogether simple and I do not intend to take your time
trying to weed out the complexities. However, I think
there are a couple of basic principles involved or problems

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3 involved which will have to be solved if this problem is
4 to be resolved. To a greater or lesser extent I think
5 the same problem exists across Canada, at least that is
6 my information. At the present time there are not ade-
7 quate training facilities in Manitoba. For instance,
8 there is no training program for clinical psychologists;
9 there are one or two courses but as yet a Department
10 of Psychology which has been developed and oriented
11 around research, academic and teaching, this kind of
12 interest in psychology has not yet identified itself
13 generally with the problem in the mental health field,
14 at least, to the extent of providing the clinical psycho-
logists.

15 Secondly, the remuneration has not been
16 sufficient to attract the appropriately trained personnel.
17 Again I notice in the brief there was a suggestion made
18 that the level of remuneration should be brought up to
19 the level of the most attractive provinces. I think that
20 is true in Manitoba at the present time, certainly in
21 psychology the provincial wage scale is, to my knowledge,
22 similar or better than the national average, perhaps one
23 of the top few. This, again, has not been satisfactory
24 because in general it does not compete with the sort of
25 remuneration that the psychologist can receive in academic
26 settings or in industry. A young student may get
27 interested in psychology because they like to play some
28 part, they take some training in the field, become discou-
29 raged in terms of their lack of opportunity for advance-
30 ment and perhaps more attractive alternatives present
themselves and so they leave. Now, in general, I think



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4 we will find the same thing is true for the social
5 worker group I know who are represented by roughly an
6 equal number. Within the three mental hospitals, again
7 with a total population of 3,000-plus, there are, I
8 believe, no more than one or two qualified social workers.
9 Perhaps Miss DesJardins will say something about this.

10 THE CHAIRMAN: Thank you, Dr. Wright.

11 MISS DesJARDINS: Looking at the charts
12 which we presented of personnel we see that in the three
13 hospitals, the three Manitoba hospitals for mental
14 diseases and the four hospitals which have psychiatric
15 wards, we have a total of four trained social workers
16 and one part-time trained social worker and three social
17 workers who are not trained; one part and one part-time
18 social worker not trained. That is a total of four
19 trained who are full-time and five who are not trained
20 full-time. At the Children's Hospital there are three
21 trained social workers and one without training who are
22 available to the psychiatric department. Our chart
23 also shows that a spot check of the hospital reveals
24 that one time there were approximately six children
25 hospitalized for psychiatric treatment. The Child
26 Guidance Clinic on the staff have 22 full-time social
27 workers, 18 of which are trained and also some of the
28 communities who are working closely with the Child
29 Guidance Clinic have three full-time social workers and
30 one half-time social worker. We do not know whether
these people are fully trained or not.

31 In our previous brief to the Government
32 of Manitoba we expressed our concern over the lack of

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these people are fully trained or not.

In our previous brief to the Board of
of Manitoba we expressed our concern over the lack of



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3 training personnel for social workers at the present
4 time. There are 30 students in the second year of the
5 course in social work at the University of Manitoba and
6 43 in the first year. Of these students there are eight
7 who are doing their field work in the Child Guidance
8 Clinic which is the only facility which is used for
9 training of social workers in the field of psychiatry.
10 Four are second year students. In 1962 there were two
11 students who requested mental health grants for study
12 and experience in the psychiatric setting and this year,
13 1961, a second year student. The School of Social Work
14 is very much interested in providing training facilities
15 for social workers in this area but feel that they are
16 unable to do so for two reasons; because of the lack of
17 well-organized social service departments in our hospitals
18 for mental diseases and because of the lack of senior
19 staff with qualifications which would enable them to give
20 the required supervision. I believe Mrs. Grieve may be
21 prepared to give you some information about the training
22 of nurses.

23 MRS. GRIEVE: If you look on page 14,
24 for instance, the Selkirk Hospital for Mental Diseases,
25 you will see that we have under nurses actually 245
26 trained. They have given us the round number there and
27 actually the number is 74 graduate nurses and we have
28 57 in training and the balance of the nurses are nurses'
29 aids. We have a clear picture there that they are very
30 short of trained staff and the same is true at the
Brandon Hospital. However, with the introduction of the
Psychiatric Nurses' Association this year they hope to

training personnel for social workers at the present time. There are 38 students in the second year of the course in social work at the University of Manitoba and 43 in the first year. Of these students there are eight who are doing their field work in the Child Guidance Clinic which is the only facility which is used for training of social workers in the field of psychiatry. Four are second year students. In 1951 there were two students who requested mental health grants for study and experience in the psychiatric setting and this year, 1951, a second year student. The School of Social Work is very much interested in providing training facilities for social workers in this area but feel that they are unable to do so for two reasons: because of the lack of well-organized social service departments in our hospitals for mental diseases and because of the lack of service staff with qualifications which would enable them to give the required supervision. I believe Mrs. Grieve may be prepared to give you some information about the training of nurses.

MRS. GRIEVE: If you look on page 14, for instance, the Selkirk Hospital for Mental Diseases, you will see that we have senior nurses actually 265 trained. They have given us the round number there and actually the number is 74 graduate nurses and we have 57 in training and the balance of the nurses are nurses' aids. We have a clear picture there that they are very short of trained staff and the same is true at the Brandon Hospital. However, with the introduction of the Psychiatric Nurses' Association this year they hope to



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3 have a better program set up to encourage more students
4 to enrol in training and to have them meet a higher
5 standard where they can qualify to nurse in other
6 provinces in western Canada and so on. In the Selkirk
7 Hospital and Brandon Hospital for Mental Diseases all
8 of the nurses in training from the Grace Hospital in
9 Winnipeg, the Children's Hospital, they spend 12 weeks
10 at the provincial hospitals training in psychiatric
11 nursing. The Winnipeg General Hospital nurses spend
12 eight weeks in the Winnipeg Psychopathic Hospital and
13 four weeks in their own psychiatric department. The
14 Misericordia spend a minimum of 14 days in their own
15 psychiatric department and they have no affiliation with
16 any other provincial hospital. We see here that the
17 registered nurses in metropolitan Winnipeg are taking
18 courses in psychiatric nursing. I might mention that at
19 the Selkirk Hospital for Mental Diseases they do hire a
20 large number of nurses' aids for positions which probably
21 could be filled better with students in training. There
22 is no training given to the ward itself at all because
23 of the shortage of teaching staff. When they go on staff
24 they go on to wards immediately without having any
25 training or any orientation whatsoever. At the Brandon
26 Hospital for Mental Diseases they do have some, they
27 have 28 hours and this includes courses in personal
28 hygiene and some nursing ethics, etc.

26 I forgot to mention here the Manitoba
27 Home for Mentally Defective Persons; the nurses have a
28 three-year course and they used to spend their total
29 time there except for several weeks at the Winnipeg
30



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four weeks in their own psychiatric department. The
Niswonger nurses spend a minimum of 12 weeks in their own
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any other provincial hospital. We see here that the
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4 General Hospital where they have their training in
5 general nursing. However, this Spring the nurses from
6 there in training will be spending six months at either
7 the Brandon Hospital for Mental Diseases or the one at
8 Selkirk and this will bring them up to taking psychiatric
9 training which will enable them to work in psychiatric
10 settings and psychiatric hospitals as well as in general
11 hospitals.

12 THE CHAIRMAN: Thank you, Mrs. Grieve.

13 MISS DesJARDINS: We have tried to
14 summarize and add to the content of our brief. We can
15 go on if you like but we feel this might be sufficient
16 to present a picture.

17 THE CHAIRMAN: I might say you have
18 presented a comprehensive picture. We know that the
19 field is so broad that it must be condensed in any form
20 of discussion such as can take place here. Now, as I
21 said to the members of the Psychiatric Association, we
22 are going to depart from our usual form of looking for
23 more information by way of questioning here, not because
24 we regard ourselves as having received all the information
25 that it is possible to get or that the subject does not
26 deserve a very great study in depth but it is because we
27 have elected, the Commission has elected, to treat mental
28 illness and one other subject as special areas of study.
29 We have commissioned two studies into the subject of
30 mental illness, the first dealing with mental illnesses
as such, being done by Dr. Richmond of the University of
British Columbia and the second study to which we have
given the title "Changing Treatment Patterns in Mental



General Hospital where they have their training in general nursing. However, this Spring the nurses from

the Brandon Hospital for Mental Diseases on the one at Selkirk and this will bring them up to taking psychiatric training which will enable them to work in psychiatric settings and psychiatric hospitals as well as in general hospitals.

MISS MCGILL: We have tried to summarize and add to the content of our brief. We can go on if you like but we feel this might be sufficient to present a picture.

THE CHAIRMAN: I will say you have presented a comprehensive picture. We know that the field is so broad that it must be condensed in any form of discussion such as can take place here. Now, as I said to the members of the Canadian Association, we are going to depart from our usual form of looking for more information by way of guest-entertaining, not because we regard ourselves as having covered all the information that it is possible to get on that but subject does not deserve a very great study in depth but it is because we have elected, the Commission has elected, to treat mental illness and one other subject as special areas of study. We have commissioned two studies into the subject of mental illness. The first study was done by Dr. Richmond of the University of British Columbia and the second study to which we have

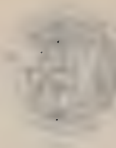


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4 Illness" which is being done by Dr. McKerrecher of the
5 University of Saskatchewan. What we have heard here
6 today, your submission, your written submission, the
7 record will be extended and will go to both Dr. Richmond
8 and to Dr. McKerrecher. It may be in the course of
9 their studies and I expect it will be in the course of
10 their studies they will be in touch with your organiza-
11 tion for further information, more detailed information,
12 as they may require it in the course of their studies.
13 Therefore, we think it desirable to leave it to the
14 two scholars and I think they are regarded as eminent
15 men in their fields, to pursue the inquiries which they
16 can work out. You may well expect to hear from them and
17 we would ask you to give them your fullest co-operation
18 when these requests are made as we expect you will do
19 even without a request.

20
21 MISS DesJARDINS: We will be pleased to
22 do it.

23
24 THE CHAIRMAN: On behalf of the Commission
25 we wish to thank you most graciously for your attendance
26 and say, as I have said to other volunteer organizations,
27 how much we appreciate the dedication that lay people
28 give to these very important health matters. I think the
29 question has been put and I think we can accept it as
30 being necessary that regardless of what plans may come
the role of the voluntary organization in health services
must necessarily continue to be a very important one.
Thank you very much. We will take a short recess before
proceeding with the next brief.

--- Short Recess



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University of Saskatchewan. What we have heard here

is a very good example of the kind of work that is being done in the field of health services.

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even without a request.

MRS. DEARHEIM: We will be pleased to

do it.

THE CHAIRMAN: On behalf of the Commission

we wish to thank you most greatly for your attendance

and say, as I have said to other volunteer organizations,

how much we appreciate the decision that my people

give to these very important health matters. I think the

question has been put and I think we can accept it as

being necessary that regardless of what plans may come

the role of the voluntary organization in health services

must necessarily continue to be a very important one.

Thank you very much. We will take a short recess before

proceeding with the next part.



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4 THE CHAIRMAN: Ladies and gentlemen, if
5 we are ready to proceed we will do so. We will now have
6 a submission from the Catholic Hospital Conference of
7 Manitoba.

8 THE SECRETARY: That will be Exhibit No.
9 72 sir.

10 --- EXHIBIT NO. 72: Submission of the Catholic Hospital
11 Conference of Manitoba.

12 SUBMISSION OF THE CATHOLIC HOSPITAL
13 CONFERENCE OF MANITOBA

14 Appearances: Sister Justinia
15 Father Durocher
16 Mr. Posyniak
17 Sister Ann Ell
18 Sister Thille
19 Sister Tetrault

20 THE CHAIRMAN: We will proceed. Who is
21 the spokesman?

22 SISTER JUSTINIA: Father Durocher will
23 read our brief.

24 FATHER DUROCHER: Mr. Chairman and members
25 of the Commission, the only reason I am speaking here is
26 that the Sisters are not used to making speeches in
27 public. As you may have noticed, Sister Justinia is a
28 bit nervous.

29 We don't intend to read the brief. We
30 will look it through, it is not very long. We have tried
to pick out a few points which to the minds of the hospitals involved in the Catholic Hospital Conference seem to us to be most urgent. Therefore, our brief is not what you might call a comprehensive one, but we do think



THE CHAIRMAN: Ladies and gentlemen, if

we are ready to proceed we will do so. We will now have
a submission from the Catholic Hospital Conference of
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THE SECRETARY: That will be Exhibit No.

72 sir.

--- EXHIBIT NO. 72: Submission of the Catholic Hospital
Conference of Manitoba.

SUBMISSION OF THE CATHOLIC HOSPITAL

CONFERENCE OF MANITOBA

Apparances: Sister Justina
Father H. H. H.
Sister Ann M.

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tals involved in the Catholic Hospital Conference seem

to us to be most urgent. Therefore, our brief is not

what you might call a comprehensive one, but we do think



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3 that these points are ones that would demand most
4 immediate attention as far as the care of the sick in
5 Manitoba is concerned.

6 You will notice that the first point
7 deals with the old question of depreciation and interest
8 charges. As you will probably know, the Manitoba Govern-
9 ment is handling this problem in the best possible way
10 as far as we know right across Canada, but we do feel
11 that if the depreciation and interest charges were
12 included in the shareable costs, this would liberate
13 more provincial money, so that the province would be able
14 to take care of other things more easily, without having
15 to have recourse to Ottawa. We also feel, as is noted
16 in the brief, that the stubbornness of the Federal
17 Government in refusing to change its attitude on this
18 point is a constant temptation to provincial governments
19 to be less generous, and to at least blame Ottawa if
20 they themselves do not do anything. This has already
21 been done in Saskatchewan, and the end result is that
22 this question tends to become political. There are
23 different parties involved in the province, and in Ottawa,
24 and all these schemes of government financing of health
25 care have implicit in them a possibility of becoming
26 directed by political considerations to a certain extent,
27 and that is one of the reasons why we think that this
28 problem should be settled before it does get too compli-
29 cated.

30 The second point is also one where we feel
there should be a little bit more logic in the Federal
financing arrangements. The Federal share of the costs

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3 of course excludes the mentally ill and the tuberculosis
4 cases. We have gotten involved in this kind of care
5 through taking over an individual foundation for mentally
6 retarded children, and this is producing a huge deal of
7 work.

8 THE CHAIRMAN: That is at the St. Boniface
9 Hospital?

10 FATHER DUROCHER: This is the St. Boniface
11 Sanatorium, which is getting into this work, and it is
12 a tremendously costly one, and under the present arrange-
13 ments, of course the Provincial Government has to carry
14 the whole load. We do not quite understand why in its
15 anxiety to care for the health and the sick the Federal
16 Government excludes mentally ill and tubercular patients,
17 although the tubercular question seems to get less as
18 time goes on, but the other one becomes bigger. Again
19 it is the problem of getting some of the funds allocated
20 to this, in order to take care of its other responsibilities.

21 We have added one note about nursing
22 personnel, because we find that a lot of our ambitious
23 schemes to take care of people come to nought, even if
24 you have the buildings to put them in, and the Sisters
25 are becoming conscious of the necessity of encouraging
26 male personnel to get into the nursing profession, where
27 they will stay, whereas the terrific turnover in the
28 nursing profession because of marriage, also brings some
29 elements to the nursing care which have been missing in
30 the past. Of course, this requires better bursaries,
and better remuneration, pension plans, and all the rest.
It is just one little angle in the question of care.

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a tremendously costly one, and under the present arrange-

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male personnel to get into the nursing profession, where

they will stay, whereas the turnover is so high in the

elements to the nursing care which have been missing in

the past. Of course, this requires better salaries,

and better remuneration, pension plans, and all the rest.

It is just one little angle in the question of care.



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4 Before going on, we got a little bit into
5 the question of relationships between government and
6 hospitals; we think that someone should make the state-
7 ment, and we have made it, the extreme importance of
8 maintaining an atmosphere of mutual confidence between
9 the Government side of all these relationships and the
10 people who are doing the work. We are working this out
11 in Manitoba, as we are in other provinces, and I think
12 on our side there are plenty of mistakes, and also there
13 are some mistakes on the Government side, with the
14 result that after a while you get involved in forms and
15 things are run too much by statistics, and averages, and
16 people who are doing the work tend to get discouraged,
17 and to content themselves with the minimum required,
18 rather than to really take part in their work with
19 great interest and enthusiasm. We think in the long
20 run this could have a very great effect on the kind of
21 care given to the sick. It is a problem that has to be
22 worked out on both sides. In our case of course we are
23 interested in stating the case of the institutions, and
24 the people who are giving the service.

25 The question of alternate care is coming
26 up more and more. Unfortunately it is being brought up
27 too often in terms of how in the world can we empty out
28 the acute care beds in the hospitals, and we feel that
29 the problem is rather how can we give this patient the
30 best possible care in accordance with his needs. Maybe
the chronically ill person may find an acute care hospital
a tiresome place to be in, it gets on his nerves and so
forth. We have just one suggestion to make, and we feel

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3 that these institutions should be very closely related
4 to hospitals. Very often, because the patients are
5 going back and forth very often, and if you are going
6 to keep transporting people back and forth it is tiring
7 and also expensive. Also, so that you do not get people
8 being classified too much by cases. Don't forget it is
9 just the one person that has this sickness, or this
10 difficulty. In this connection, Sister Tetrault has
11 come down from St. Rose, which is quite a ways up north.
12 She used to run one of the huge institutions for the
13 aged and bedridden in St. Boniface, and now has a
14 smaller hospital where the problem comes up when three
15 or four people, being chronic or aged and bed-patients;
16 there is not enough of them to build an institution.
17 None of them want to be sent far away from their rela-
18 tives and friends, and we think something ought to be
19 worked out in the hospitals, or the immediate vicinity.
20 The same thing in the city hospitals.

21 THE CHAIRMAN: Father Durocher, just at
22 that point, has there been anything done here similar
23 to the situation in Gravelbourg, where you have the old
24 folks' home adjacent to the hospital?

25 FATHER DUROCHER: Well, there are plans
26 in that direction, but so far nothing really has been
27 done here. The problem we have been having here is
28 trying to take over existing facilities such as the St.
29 Boniface Sanatorium and the tubercular sanatoria in
30 other places in the province have been kind of transformed
into this chronic care business. As a matter of fact I
don't think anybody knows right now what we are going to do

to keep transporting people back and forth it is simply
and also expensive. Also, so that you do not get people
being classified too much by cases. Let's forget it is
just the one person that has this sickness, or this
difficulty. In this connection, Sister Margaret has
come down from St. Rose, which is about a ways up north.
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aged and bedridden in St. Rose, and now has a
smaller hospital where the patients come up when they
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there is not enough of them to build an institution.
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tives and friends, and we think something ought to be
worked out in the hospital, or the immediate vicinity.
The same thing in the city now.

that point, has there been anything more done similar
to the situation in Gravelbourg, where you have the old
folks' home adjacent to the hospital?

FATHER DUBOIS: Well, there are plans

in that direction, but so far nothing really has been
done here. The problem we have been having now is
trying to take over existing facilities and use the St.
Boniface Sanatorium and the tuberculosis sanatorium in
other places in the province have been kind of transformed
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3 about this. The Willard Report of course recommended
4 that an extension of treatment and care, that facilities
5 be provided right next to St. Boniface Hospital, that a
6 new institution be erected there. We think that 300
7 beds is a pretty big operation though for this kind of a
8 thing.

9 I think you will find in the last part
10 of the brief an affirmation of why the Sisters and others
11 in the church and the hospital feel. Other people are
12 putting forth opinions with regard to the rights of
13 citizens, and we thought that we should put forth our
14 ideas on the subject. It is very hard to define exactly
15 what a Catholic hospital is, particularly in this part
16 of the country where it is not a confessional, denomina-
17 tional institution. It is an institution which is
18 operated by a community of persons who are doing it for
19 a religious motivation, and I think one of the characteris-
20 tics which everybody recognizes is the economy of the
21 operation. The Sisters individually in this group are
22 very economical in their activities, and the last point,
23 which is extremely important, is that all the Catholic
24 hospitals, at least in Manitoba, are considered community
25 hospitals. The people who go there go not only because
26 they are Catholics, because of the Catholic code of
27 ethics in their functioning, but because they like the
28 particular kind of care which is given them there, and
29 this explains why the number of, the percentage of patients
30 taken care of in these hospitals is actually much
larger than the actual Catholic population of the
province. We try to understand what this particular

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4 thing is, because we think that people should have
5 available to them the possibility of choosing as much
6 as can be done, where there is at least a sufficient
7 density of population, this or that hospital, or this
8 or that institution, insofar as religious, cultural,
9 social or purely personal preferences affect their choice.
10 This goes for patients and doctors, as well as those who
11 offer their services in doing this.

12
13 To sum up, we feel that although it is
14 obvious that government must help nowadays more and more,
15 financially particularly, and with expert help in many
16 fields that a really solid health care program cannot be
17 built except on the theory that individuals must be
18 encouraged to do whatever they can, and group together
19 to do what they cannot do by themselves, and if they
20 cannot then, the Government should step in, but not
21 take over except in extreme cases.

22
23 I was not supposed to talk this long, Mr.
24 Chairman. I got carried away here. If you have questions,
25 Mr. Posyniak is our expert on depreciation and interest
26 charges. Sister Tetrault is in the field of the care of
27 the chronic and aged. Sister Ann Ell for the mentally
28 retarded children.

29
30 THE CHAIRMAN: Father Durocher, could you
tell the Commission the percentage of hospital beds that
your Conference represents in terms of the overall bed
capacity in Manitoba?

SISTER JUSTINIA: I wouldn't know the
percentage, but I have the number of beds.

THE CHAIRMAN: All right, the numbers.



thing is, because we think that people should have available to them the possibility of choosing as much as can be done, where there is at least a sufficient density of population, this or that hospital, or this or that institution, insofar as religious, cultural, social or purely personal preferences affect their choice. This goes for patients and doctors, as well as those who

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I was not supposed to talk this long, Mr. Chairman. I got carried away here. If you have questions Mr. Posyniak is our expert on legislation and insurance charges. Sister Terrell is in the field of the care of the chronic and aged. Sister Ann Hill for the mentally retarded children.

THE CHAIRMAN: Sister Terrell, could you tell the Commission the percentage of hospital beds that your Conference represents in terms of the overall bed

capacity in Manitoba?

SISTER JUSTINIA: I wouldn't know the



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4 SISTER JUSTINIA: Well, altogether general
hospital beds is 1,552.

5 THE CHAIRMAN: Out of a total of what?

6 FATHER DUROCHER: It is around 6,000.

7 SISTER JUSTINIA: And then homes for the
8 aged and the retarded children put together, we have
9 972 beds.

10 THE CHAIRMAN: Is there any restriction
11 in a religious community which might desire to come into
12 Manitoba, into the hospital field? Is there any restric-
13 tion on such a community coming into, say, Winnipeg and
saying we are going to build a hospital here?

14 FATHER DUROCHER: I don't think there are
15 any restrictions. The big problem is finding the
16 community which has sufficient trained personnel. There
17 are several out-of-town communities, some towns out of
18 Winnipeg, which at the present time are seeking the
19 services of the nuns. Of course, in two cases these are
20 the French-Canadian communities which want nuns of that
21 particular background, and particularly for the care of
22 the aged. There is a great demand at the present time
for the services of the Sisters in this line.

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tion on such a community coming from, say, Winnipeg and
saying we are going to build a hospital there?

PAULINE DUKACHEK: I don't think there are

any restrictions. The big problem is finding the
community which has sufficient trained personnel. There
are several out-of-town communities, some towns out of
Winnipeg, which at the present time are seeking the
services of the hospital. Of course, in two cases these are
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4 We do have two, towns where the hospital has been taken
5 over by the municipality, again for financial reasons,
6 and in each case Sisters have been retained by the
7 municipalities on a contract basis because they did not
8 want the nuns to leave the place.

9 THE CHAIRMAN: That is, to administer
10 the hospital?

11 FATHER DUROCHER: Yes. We feel in
12 Manitoba the general attitude towards the Sisters in
13 the field of hospital care is very pleasing and, as a
14 matter of fact, that is why we didn't have to present a
15 huge brief because the associated hospitals and Catholic
16 hospitals work hand in hand all the time; and we had
17 just a few points of our own to mention.

18 THE CHAIRMAN: The reason I ask that is
19 that I think there are some provinces where there must be
20 a prior permission from the Government to go into the
21 field with a new hospital or with an extension or an
22 addition to a hospital. That doesn't exist in Manitoba?

23 FATHER DUROCHER: No, not outside the
24 purely financial assistance to be made. We have a
25 problem to the extent that in some parts of the province
26 the hospital unit, or the health unit, is not organized,
27 and if it is a question of building there, then the
28 raising or the issuing of debentures by the local govern-
29 ment may cause complications, because the voluntary
30 hospital is on the spot, but in actual fact it doesn't
cause too much trouble, because outside the Catholic
hospitals the vast majority of the beds are taken care
of by voluntary institutions, including the Winnipeg

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4 General. So; the voluntary hospital is pretty well
5 treated in the province.

6 THE CHAIRMAN: I may have misunderstood
7 the situation. Your municipal hospital situation does
8 not loom large in the overall picture?

9 FATHER DUROCHER: In the number of hospi-
10 tals, yes, but not in the number of beds because the
11 Winnipeg General is really a voluntary hospital, and St.
12 Boniface.

13 MR. POSYNIAK: Mr. Chairman, you were
14 wondering whether prior permission would be needed:
15 under the legislation of this province the Commissioner
16 of Hospitalization must give his approval for any addi-
17 tional beds or any new hospitals before they are
18 constructed.

19 COMMISSIONER McCUTCHEON: If you want to
20 come under the plan?

21 MR. POSYNIAK: That is right.

22 THE CHAIRMAN: Supposing you had the
23 permission, then it is a matter of getting the capital
24 money to build: do I understand that 80% of that -- or,
25 that there is provision whereby 80% can be obtained
26 through the Government of Manitoba, plus the Dominion
27 contribution of \$2,000 a bed?

28 MR. POSYNIAK: Basically, the way it
29 works, if a program, for example, cost \$1,000,000, the
30 community itself would have to raise initially \$200,000.
There would be grants from both the Provincial and
Federal Governments which would amount to approximately
another \$200,000. The balance of \$600,000 would be

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Mr. FOSDYK: That is right.

Mr. CHAIRMAN: Assuming you had the

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3 borrowed, perhaps. We feel the hospitals in this
4 province are very fortunate in that there is low
5 interest on the long-term debt. In addition, the
6 hospital can recover through depreciation charges the
7 cost to them -- that is, the original 20%, and the
8 amount of the borrowings, which is the \$600,000.

9 COMMISSIONER McCUTCHEON: How do they
10 recover that?

11 MR. POSYNIAK: Through depreciation
12 charges.

13 THE CHAIRMAN: That is built into the
14 per diem rate?

15 MR. POSYNIAK: Yes.

16 COMMISSIONER McCUTCHEON: But that is all
17 borne by the Federal Government?

18 MR. POSYNIAK: It is included in the rate
19 structure of the hospital.

20 THE CHAIRMAN: But it is not a shareable
21 cost with the Dominion Government?

22 MR. POSYNIAK: That is right. However,
23 this recovery of depreciation has certain strings
24 attached: it must be used in a certain manner by the
25 hospitals.

26 THE CHAIRMAN: You can't just export it
27 and send it away?

28 MR. POSYNIAK: That is basically true.
29 You have to apply it to either your long-term debt or
30 the acquisition of additional assets.

THE CHAIRMAN: You made reference in the
brief to economy of operation: I don't want to make any

1 borrowed, perhaps. We feel the hospitals in this
2 province are very fortunate in that there is low
3 interest on the long-term debt. In addition, the
4 hospital can recover through depreciation charges the
5 cost to them -- that is, the original cost, and the
6 amount of the borrowings, which is the \$20,000
7 COMMISSIONER MONTGOMERY: Now do they

8 recover that?

9 MR. BOSWICK: Through depreciation

10 charges.

11 THE CHAIRMAN: What is done with the

12 COMMISSIONER MONTGOMERY: And that is all

13 borne by the Federal Government?

14 MR. BOSWICK: It is included in the rate

15 structure of the hospital.

16 THE CHAIRMAN: But it is not a charge

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18 this recovery of depreciation has certain savings

19 attached; it must be used in a certain manner by the

20 hospitals.

21 THE CHAIRMAN: You can't just report it

22 and send it away?

23 MR. BOSWICK: That is exactly true.

24 You have to apply it to either your long-term debt or

25 the acquisition of additional assets.

26 THE CHAIRMAN: You made reference in the

27 brief to economy of operation; I don't want to make up



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4 invidious comparisons, but how does that reflect in the
5 per diem rate to hospitals of comparable size and
6 comparable service?

7 MR. POSYNIAK: I don't think you can
8 compare hospitals closely. Strangely enough, even the
9 most identical hospitals have their differences in
10 services, and you can't logically compare on this basis.
11 However, I think the Father's meaning was that the
12 Sisters provide direct supervision and are actually the
13 owners of the hospital, and that type of supervision,
14 perhaps, brings more economy, and a layman type of organi-
15 zation, where the actual ownership is not vested in,
16 say, department heads.

17 FATHER DUROCHER: I would like to add
18 that the value of the service of the Sisters is not
19 calculated on the same basis as that of other persons
20 doing the same job, as far as supplementary work is
21 concerned. There is no question of time-and-a-half and
22 things of that nature. We are not complaining about it.
23 That is what we are there for, and we are glad to do it,
24 but it does represent some savings in the long run.

25 THE CHAIRMAN: What I had in mind was
26 when a thing like this existed, such as in Saskatchewan,
27 where in a main city you will have two hospitals of
28 virtually the same size and service, where the per diem
29 rate may vary by as much as \$2 a day in favour of the
30 private hospital.

31 MR. POSYNIAK: This basically may not be
32 justified by economy of operation. There are many
33 factors involved, and I would not care to comment in that



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3 direction at all.

4 THE CHAIRMAN: We had the nursing brief
5 yesterday afternoon with the suggestion that the future
6 ought to see the nursing school more divorced from the
7 hospital: have you any views to express on that? I
8 take it some of your hospitals operate nursing schools?

9 MR. POSYNIAC: Yes, sir.

10 FATHER DUROCHER: Mr. Chairman, Sister
11 Thille will take care of that question. I would like to
12 point out, with all respect to Sister Thille, that Sister
13 Ste. Odilon is the one who worked on this brief, but she
14 was called to Montreal. However, Sister Thille was in
15 on the discussions and knows the line of thought on this
16 matter.

17 SISTER THILLE: Mr. Chairman, I understand
18 and I feel that the Canada Hospital Conference of Mani-
19 toba feels the same, in that the cost of nursing educa-
20 tion is constantly rising with the improvement of nursing
21 education programs. We feel that when nursing educators
22 in Manitoba and throughout Canada realize there is a
23 considerable upgrading required in our program -- and
24 here I may mention a report submitted a few years ago,
25 that the Canadian Nursing Association has presently
26 undertaken a program and we are thinking of organizing
27 an accreditation program. The nursing educational pro-
28 grams are becoming gradually and will continue to become
29 more educational by nature. The students are being
30 counted upon less for service and this in turn increases
the demand for additional nursing personnel.

The other problem is how to determine how

direction at all.

THE CHAIRMAN: We had the nursing brief yesterday afternoon with the suggestion that the future ought to see the nursing school more divorced from the hospital; have you any views to express on that? I take it some of your hospitals operate nursing schools?

Thillie will take care of that question. I would like to point out, with all respect to Sister Thillie, that Sister Ste. Odilion is the one who worked on this brief, but she was called to Montreal. However, Sister Thillie was in on the discussions and knows the line of thought on this

and I feel that the Canada Hospital Conference of Manitoba feels the same, in that the cost of nursing education is constantly rising with the improvement of nursing education programs. We feel that when nursing educators in Manitoba and throughout Canada realize there is a considerable upgrading required in our program -- and here I may mention a report submitted a few years ago, that the Canadian Nursing Association has presently undertaken a program and we are thinking of organizing an accreditation program. The nursing educational programs are becoming gradually and will continue to become more educational by nature. The students are being counted upon less for service and this in turn increases the demand for additional nursing personnel.

The other problem is how to determine how



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3 much financial assistance the schools or nursing may
4 expect to obtain from provincial hospital services plan.
5 That is why it is suggested that more bursaries be
6 more readily available to students so they will be
7 expected to share a greater part of the educational
8 cost.

9 THE CHAIRMAN: Have you a view to express
10 on this idea of separating the nursing school from the
11 hospital?

12 SISTER THILLE: That may come with time,
13 but I don't feel we have gone that far as yet. I think
14 that although we realize that the provincial hospital
15 services plan should probably not be responsible for the
16 educational program of the students, that there should be
17 some other means set up whereby the schools could
18 continue to educate their students in another way. I
19 feel, though, that the students still have to be fairly
20 closely associated with the hospitals, because that is
21 where they will be getting their education.

22 COMMISSIONER GIRARD: I would like to ask
23 Sister Thille about the idea of bringing more male nurses
24 into the picture. This was brought up by Father Durocher
25 a few minutes ago, and I think there is a lot of thought
26 about that in different parts of Canada. Personally --
27 and I am speaking of my own personal reaction -- I think
28 we need male nurses more and more, but what are you doing
29 to attract male nurses into schools of nursing, or do you
30 have any suggestions on how schools of nursing can attract
more male nurses?

31 SISTER THILLE: When this recommendation

much financial assistance the schools on nursing may expect to obtain from provincial hospital services plan. That is why it is suggested that more nurses be more readily available to students so they will be expected to share a greater part of the educational cost.

THE CHAIRMAN: Have you a view to express on this idea of separating the nursing school from the hospital? Sister THILDE: That may come with time, but I don't feel we have gone that far yet. I think that although we realize that the provincial hospital services plan should probably not be responsible for the educational program of the students, there should be some other means set up whereby the schools could continue to educate their students in another way. I feel, though, that the students still have to be fairly closely associated with the hospital, because that is where they will be getting their education.

COMMISSIONER GIRARD: I would like to ask Sister Thilde about the idea of bringing more male nurses into the picture. This was brought up by Father Durocher a few minutes ago, and I think there is a lot of thought about that in different parts of Canada. Personally -- and I am speaking of my own personal reaction -- I think we need male nurses more and more, but what are you doing to attract male nurses into schools of nursing, or do you



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3 was made a few years ago, I am afraid I wasn't in on the
4 report, and I am not prepared to say anything has been
5 done in that respect.

6 COMMISSIONER GIRARD: We have often been
7 told that to attract more male nurses we had to do something
8 about remuneration of nurses because men tend to get
9 married, and when they do they have to support a family
10 and, of course, when a female nurse gets married it is
11 not her problem; her husband supports her. But, if we
12 have a male nurse and he gets married, he has to support
13 a family, and until these recent years I don't know how
14 he could have done that on some of the salaries they
15 were getting. Do you feel this has been a deterrent to
16 the cause of having more male nurses?

17 SISTER THILLE: It could be. I was
18 director of a nursing school for a few years, and my
19 experience there was that we did not attract male nurses,
20 and the few who did apply never actually even commenced
21 their course.

22 COMMISSIONER GIRARD: If some applicants
23 applied to your school, would you take them?

24 SISTER THILLE: Definitely.

25 COMMISSIONER GIRARD: And how would you
26 foresee using the male nurses once they are graduated --
27 in specialties, or general practice, supposing we did
28 have a lot in nursing, which I hope will happen before
29 too long.

30 SISTER THILLE: I think, before they would
go into general practice, they would probably be in
specialized departments, because I don't think they would



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4 increase that rapidly, that you would probably want to
5 begin by putting them into specialties.

6 COMMISSIONER GIRARD: Is it generally
7 known that if you had applicants you would take them?

8 SISTER THILLE: Speaking for St. Boniface,
9 I think it is generally known.

10 COMMISSIONER GIRARD: And you have never
11 had any applicants?

12 SISTER THILLE: We have had applicants,
13 but they never actually commenced the course. We had
14 few applicants, but we did have applicants.

15 FATHER DUROCHER: There are now three
16 students at Misericordia. Sister Ste. Odilon would
17 have been able to speak about this. She has already
18 produced one last year, and one is graduating this year.
19 One of the ways we can go about it is that every time a
20 male nurse graduates they make a big splash about it in
21 the newspapers, and other men feel it may be worthwhile
22 looking into. I suppose it is very like the old problem
23 of how women got into fields reserved for men. It takes
24 pioneers and a lot of persistence on their part, because
25 in entering into a school they would find an organization
26 which, in this case, would be definitely feminine in tone.
27 There have to be all kinds of exceptions and it takes
28 pioneer people to do it. I think in Winnipeg the publi-
29 city given to a few cases is something; and some have
30 gone into licensed practical nursing. It is like the
water in the trough: once you get a little water in, it
starts coming out. However, nobody has the secret of the
success yet. You have already mentioned that finances



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4 are extremely important, and if we take a long-term
5 view we will find it is worth paying them because the
6 investment in the training of male nurses is going to
7 produce results for a good length of time.

8 COMMISSIONER GIRARD: They are apt to
9 stay longer in nursing.

10 FATHER DUROCHER: Yes.

11 COMMISSIONER GIRARD: Do you know of this
12 instance where you said Sister Ste. Odilon had started
13 taking male nurses -- are the conditions the same as for
14 female students, and if they can't have them live in the
15 residence -- which I presume they cannot -- do they give
16 them a certain sum for their room outside? What are
17 the conditions made to them, do you know?

18 MR. POSYNIAK: Fortunately, we have a
19 residence close to the hospital where we house these
20 three male students. They are not, of course, anywhere
21 near the other nursing students.

22 COMMISSIONER GIRARD: Well then, the
23 conditions are the same as for female students?

24 MR. POSYNIAK: Yes, the conditions are
25 basically the same.

26 FATHER DUROCHER: I think I could add a
27 word or two about what Sister Thille said about her
28 attitude towards the changing pattern of nursing education.
29 We don't react so wildly out here as they may do in other
30 parts of the country, but in talking it over we didn't
see any difficulty in not requiring residence in the
third year. In fact, we might just as well see what they
can do flying on their own wings, although everybody was

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MR. FOSYTH: Certainly, we have a residence close to the hospital where we house these three male students. They are not, of course, anywhere near the other nursing students.

COMMISSIONER GIRARD: Well, then, the conditions are the same as for female students?

MR. FOSYTH: Yes, the conditions are

basically the same.

FATHER DEACON: I think I could add a

word or two about what Dr. Nelson said about his attitude towards the changing pattern of nursing education. We don't react so wildly out here as they do in other parts of the country, but in talking it over we didn't see any difficulty in not requiring residence in the third year. In fact, we might just as well see what they can do flying on their own wings. Although everybody was



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4 afraid that a first-year resident could be pretty well
5 justified. First of all, a lot of parents won't let
6 their girls go to the big city and live by themselves,
7 if they are young. Secondly, the girls want to: in
8 some places where we have given them the choice they go
9 into the residence -- at least, in the first year; but
10 in the second year it is a little different. There is
11 a feeling among the older nuns too that the younger
12 modern girl is not quite the naive person she was maybe
13 20 or 30 years ago and does not need to be protected so
14 much and takes less well to common discipline. You
15 have to take that into consideration.
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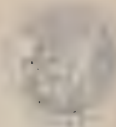
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4 They are all sure that one year's residence should be
5 solid, the second year there may be a bit of variation
6 according to their tests and the third year, absolute
7 freedom. This involves, of course, paying sums of money
8 to them for the room and board if they are not staying
9 in a residence. Now, we get into a big question, I
10 think we have some socialists amongst the Sisters
11 because some say if you do not provide them with a lot
12 of money to board and room these poor girls are not
13 going to be able to study nursing. We want to know
14 where the poor girls are because there are none left,
15 they spend money hand-over-fist. We often get into an
16 argument over that. However, it would require, not
17 necessarily an attractive, but a reasonable financial
18 arrangement if they were not living in a residence. I
19 think obviously it would cost more money because two
20 can live more cheaply than one in this kind of set-up.
21 As far as services are concerned, I think again I can
22 say that there is a lot of new thinking going on. Some
23 seem to think that instead of this being considered as
24 contributory service the girls should pay for the
25 privilege of working in the hospital because to a certain
26 extent they are getting in the way, they are a little
27 bit expensive. This may be an extreme view but it has
28 been seen in some of the other professions where a person
29 gets paid for doing the work. In the old days they paid
30 for doing it. It is not a question of cheap labour, it
is a question of conviction and in this kind of a profes-
sion you cannot learn everything out of books, there has
to be a certain to and fro business in it with the books



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3 and practical work mixed up. Many of them go into
4 specialized training practically right after their
5 nursing school and if they do not get some hard, down
6 to earth brass button work during their training they
7 will never get it and will lack something which is essen-
8 tial to a nurse. I have talked with quite a few of the
9 Sisters around the province and this is the impression I
10 get.

11 COMMISSIONER GIRARD: Anyone in the
12 nursing profession knows that the education of nurses
13 is by no means something that is not costly and it is
14 getting very costly. It is probably this that has given
15 rise to the idea that financially schools should be
16 separated from the hospital. When I talk about "separate"
17 I say financially because there is a lot of talk going
18 on about independent schools and everybody does not have
19 the same conception about our independent school that I
20 have. When I talk about independent schools I talk of
21 more financially independent schools than having a school
22 two miles off from the hospital. That is not really
23 what we think, we think of financially independent
24 schools.

25 As for living in residence, I think the
26 idea has prevailed in the east that this is not necessary;
27 that the student live in. There are some students that,
28 of course, could not take nursing if they did not have
29 a residence to live in, that is true. I think you will
30 find in most schools, if the students' families live in
town and the student wants to live out, they will let her
live out in second and third year and even in first year.



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4 I personally have three students in first year in my
5 school that are living with their families in the city
6 and they can do work anyway, they will produce the same
7 kind of work if they stayed at home as they would if
8 they lived in. I think we are thinking more or less
9 along the same lines on a lot of these things. When I
10 say we are thinking along the same lines I also mean the
11 religious orders because the nursing associations always
12 consult with the different kinds of schools. We do not
13 have one thinking for lay nurses and one thinking for
14 the religious order nurses. I think you will bear me
15 out that the Association tries to get the thinking of
16 the whole group and that is why we are thinking the same
17 on these questions.

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19 FATHER DUROCHER: Sister Ste. Odilon
20 could do this so much better. I think the point is that
21 the practice of medicine depends so much on the matter
22 of team, everybody has got a part to play and they have
23 to fit into the group. The best hospital is where the
24 people fit in and the rules and regulations are looked
25 after. She feels this is extremely important, the girls
26 having this experience of living together in a group and
27 get along with the others. This weeds out those people
28 who are such rugged individualists that they could never
29 fit into the work system. This is an experience for
30 them to work in a group and I think it is something
that should not be overlooked in assessing that situation.

THE CHAIRMAN: Father Durocher, anyone
may answer this. We had discussions here and I think
the Sisters were sitting in while the discussion was

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THE CHAIRMAN: Father Dwyer, anyone

may answer this. We had discussions here and I think the Sisters were sitting in while the discussion was



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4 going on about utilization in hospitals. Have you or
5 has any of those with you this afternoon any observations
6 to make on this subject of the utilization or over-utiliza-
7 tion of hospital accommodation?

8 MR. POSYNIAC: I think this is basically
9 the plans as they have developed in Canada encourage
10 over-utilization. They pay a certain premium and for
11 an individual case a certain premium and in return for
12 this premium they can have most of the services of any
13 hospital free of charge. There is no financial bar to
14 attending all the necessary inner services that might be
15 needed. This perhaps encourages over-utilization.
16 However, the hospitals feel that is a three-party deal
17 with the Government in trying to control utilization it
18 cannot force or put pressure on hospitals to go within
19 certain limits. This is a three-party responsibility,
20 the public, the medical profession and the hospitals as
21 well as the Government to work out legislation which
22 perhaps won't create over-utilization. I think we all
23 have our responsibilities and through mutual co-operation
24 and mutual understanding I think this can be solved.
25 I think everybody is conscientious, all parties are
26 conscientious.

27 THE CHAIRMAN: Since your Conference may
28 represent more of the rural hospitals than the three
29 gentlemen we heard from earlier in the afternoon, are
30 you able to give us any information on over-utilization
in the smaller and rural hospitals? Sister Tetrault,
you have had both a big hospital and a small one?

SISTER TETRAULT: A 70-bed hospital.



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and mutual understanding I think this can be achieved.
I think everybody is concerned, all parties are
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MR. CHAIRMAN: Since your Conference may

represent more of the rural hospitals than the three
gentlemen we heard from earlier in the afternoon, are
you able to give us any information on over-utilization
in the smaller and rural hospitals? Sister Terhune,
you have had both a big hospital and a small one.
SISTER TERHUNE: A 70-bed hospital.



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4 THE CHAIRMAN: You had a hospital with
5 far more beds than that at one time, did you not?

6 SISTER TETRAULT: Yes, I was administrator
7 of a 400-bed nursing old people. Our beds were fully
8 occupied the year round there. At my hospital now we
9 have only the one doctor and we could use more patients
10 off and on but I think we are doing very well. We have
11 a few cases that should be in nursing homes but the
12 question is always that they want to stay around home
13 and you cannot do anything about it.

14 THE CHAIRMAN: St. Rose, that is south
15 of Dauphin?

16 SISTER TETRAULT: Yes.

17 THE CHAIRMAN: Are there any facilities
18 at Dauphin?

19 SISTER TETRAULT: Yes, there is a smaller
20 home of 30 beds, that is the only one I know of around
21 there. It is quite a distance.

22 COMMISSIONER BALTZAN: As you well know,
23 I am very well aware of all the problems that were
24 presented this afternoon. I would like to say to you
25 that I am also interested in the answer to your prayers.
26 Mr. Chairman, would you grant me a special dispensation
27 to interject a personal note?

28 THE CHAIRMAN: You will do it without my
29 permission anyway.

30 COMMISSIONER BALTZAN: Thank you. May I,
and I do wish to pay my respects to this delegation
arising out of my many long years of happy hospital
associations and personal relationships with your

THE CHAIRMAN: You had a hospital with

far more beds than what at one time, did you not?

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have only the one doctor and we could use more patients

off and on but I think we are doing very well. We have

a few cases that should be in nursing homes but the

question is always that they want to stay around home

and you cannot do anything about it.

THE CHAIRMAN: So, yes, that is about

of laughing?

THE CHAIRMAN: Are there any facilities

at laughing?

SISTER TETRAULT: Yes, there is a smaller

home of 80 beds, that is the only one I know of around

there. It is quite a distance.

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presented this afternoon. I would like to say to you

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arising out of my many long years of happy hospital

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2
3 counterpart in the Province.

4 FATHER DUROCHER: Thank you very much.

5 THE CHAIRMAN: Thank you very much
6 Father Durocher and Sisters and Mr. Posyniak. We are
7 grateful to you for having responded to the invitation
8 to come. Thank you again.

9 The next brief is that of the Cerebral
10 Palsy of Manitoba.

11 THE SECRETARY: That will be Exhibit 73.

12 --- EXHIBIT NO. 73: Submission of the Cerebral Palsy
13 of Manitoba.
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SUBMISSION OF THE CEREBRAL PALSY OF MANITOBA

Appearances: Dean Nicolson
A. Armand Dureault

THE CHAIRMAN: Yes, gentlemen.

MR. DUREAULT: Mr. Chairman, madam and gentlemen: The Cerebral Palsy of Manitoba is a fairly new organization in Manitoba, organized only last Fall. This organization has yet no legal status although we are in the process of applying for incorporation. Mr. Nicolson will tell you about the need for such an organization as well as the plans that he has. At the moment there are something like 40 parents, that is husbands and wives, with cerebral palsied children who belong to this organization. Mr. Nicolson himself is the father of cerebral palsied twin boys so he is very familiar with the problem and also a very devoted President of this association. Mr. Nicolson has attended many seminars and conferences in the United States where the United Cerebral Palsy Organization, I understand, are very prominent in all of the States of the Union but one. I will now pass the chair over to Mr. Nicolson who will tell you about this organization.

THE CHAIRMAN: Thank you.



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4 MR. NICOLSON: This brief is being
5 submitted by the Cerebral Palsy of Manitoba on behalf
6 of the multiple handicapped cerebral palsy victims in
7 Manitoba. By multiple handicapped, in this case we mean
8 the cerebral palsied children who suffer various degrees
9 of mental retardation as well as physical disabilities.
10 Up until this date, these children have been completely
11 disregarded by any existing organization in Manitoba.
12 It is very apparent that there have been no provisions
13 made to include these children in the present Charters
14 now held by these organizations. By one organization
15 the child is refused any consideration due to his immobi-
16 lity; this organization has given these children deep
17 sympathy, but have stated that they will not be included
18 in their Charter in the foreseen future. The other
19 organization that has been approached, The Crippled
20 Children, has likewise refused these children help due
21 to the possibility of mental involvement.

22 After years of extensive study by the
23 American College of Cerebral Palsy in the United States,
24 it has been established that due to the fact that cerebral
25 palsy is the most complex and most crippling affliction
26 known to man, it should definitely be handled and spon-
27 sored as a separate organization.

28 By applying the cerebral palsy rate to
29 the population of Manitoba, we find that approximately
30 three hundred children in the Greater Winnipeg Area,
and another three hundred in the rural areas of Manitoba
require assistance. On their behalf we submit the
following brief outlining their immediate requirements



and also the future of the cerebral palsied in Manitoba:

1. DAY CENTRE

Transportation for these children would of course have to be provided. This has been promised by various service clubs. This centre would include a classroom. In this classroom the child would have the opportunity to:

- a) Develop his capacities to the best of his ability in the academic subjects.
- b) Socialize with children in the same category as himself.
- c) Receive speech training.

Therapy Room - in the therapy room the child would have the opportunity to receive physiotherapy and occupational therapy according to his needs. This day centre could also be used for the teenage and the adult cerebral palsied who at this time are receiving no organized form of recreation or group therapy. Besides being of unmeasurable benefit to the cerebral palsied himself, this centre would enable the parents of these children to fulfill their obligations to other members of their family and also their community. In other words, these parents could, for the first time since their cerebral palsied child was born, live a reasonably normal life.

2. SHORT STAY RESIDENCE

This residence would give an opportunity to the parents whose children are attending the day centre to place their child for short stays. This would enable the parents to recuperate from operations or



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4 breakdowns in health, and also an opportunity to get a
5 well-earned vacation. The short stay residence in
6 Winnipeg could be accomplished very easily if one floor
7 of one wing in the St. Boniface Sanatorium be used for
8 this purpose. Due to the fact that the Sanatorium is
9 directly opposite the University of Manitoba and that it
10 does now contain two floors of retarded children, it would
11 be very convenient for the students from the medical
12 faculty and also the educational faculty to gain practical
13 experience in the field of medicine and special education.
14 This ward would contain twenty to thirty beds with a
15 classroom and physiotherapy room, etc. The main purpose
16 of having this residence in Winnipeg is to provide the
17 opportunity for the medical advisory board to subject
18 the child to complete evaluations. This evaluation
19 would be the team approach which would include a pedia-
20 trician, a neurologist, speech therapist, physiotherapist,
21 an eye specialist and a dentist. Also at this time we
22 would have a local brace man and a specialist in the
23 manufacture of orthopedic equipment see the children and
24 follow their progress.

25 3.- PERMANENT RESIDENCE

26 This residence would be a wing of the
27 present Home at Portage la Prairie for Mental Defectives.
28 At present when the cerebral palsied child becomes too
29 much of a burden for the family, regardless of his I.Q.,
30 he is institutionalized in the Manitoba Home at Portage
la Prairie, where he is placed in the infirmary. At the
present time there is no special equipment available,
such as braces, walkers, stand-up tables, or special

breakdown in health, and also an opportunity to get a

well-earned vacation. The short stay residence in

Winnipeg could be accomplished very easily if one floor

of one wing in the St. Boniface Sanatorium be used for

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directly opposite the University of Manitoba and that it

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faculty and also the school faculty to gain practical

experience in the field of medicine and special education

This ward would contain twenty to thirty beds with a

classroom and physiotherapy room, etc. The main purpose

of having this residence in Winnipeg is to provide the

opportunity for the medical students to observe

the child to complete examinations. This institution

would be the team approach which would include a pediatrician,

neurologist, speech therapist, physiotherapist

an eye specialist and a dentist. Also at this time we

would have a local nurse and a specialist in the

manufacture of orthopedic equipment and the children and

This residence would be a wing of the

present Home at Portage la Prairie for Mental Defectives.

At present when the cerebral palsy child becomes too

much of a burden for the family, regardless of his age,

he is institutionalized in the Manitoba Home at Portage

la Prairie, where he is placed in the infirmary. At the

present time there is no special equipment available,

such as ramps, wheelchairs, standing tables, or special



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3 chairs.

4 These people are fed, washed, and spend
5 most of their time in cribs due to the lack of staff
6 who are usually supervising the mobile children. It is
7 the ambitions of the Cerebral Palsy of Manitoba to
8 sponsor a Ward for the cerebral palsied and supply equip-
9 ment, televisions, and other necessities for these people.
10 This type of residence is an absolute necessity as this
11 is one of the main concerns of the parents of the cere-
12 bral palsied, as at this time there is absolutely no
13 future for their children. It is our sincere hope that
14 these people could attend classes and obtain some form
15 of recreation. Upon the death of the parents it would
16 be very unfair to attempt to have other members of the
17 family accept the enormous responsibility of the cerebral
18 palsied person.

17 4. FEDERAL ASSISTANCE

18 At the present time the estimated cost
19 supplied by the Province for the upkeep of the child in
20 a permanent residence supplying custodial care is
21 \$4,500.00 a year. If the parents of the cerebral palsied
22 children were to receive a pension similar to the Old Age
23 Pension, so as to help alleviate the financial burden,
24 and with the assistance of the Cerebral Palsy of Manitoba,
25 we feel that it would be a tremendous saving to the tax-
26 payer. If this pension was given to the parents at the
27 time it was determined that the child was cerebral palsied,
28 we are positive that the parents would make every effort
29 to retain the child in his home. The medical people
30 have been preaching for years that there is no environment



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3 more beneficial than that of the child's home. Also,
4 the child would become part of the community of which it
5 is his right, and he would also be receiving his mother's
6 love and that of his entire family.

7 It is to this goal that we have committed
8 ourselves as the Cerebral Palsy of Manitoba to make every
9 effort to help these children carry their tremendous
10 cross. Organizations in the United States have proven
11 that multiple handicapped cerebral palsied children can
12 be helped a great deal.

13 It is the objective of the Cerebral Palsy
14 of Manitoba to give every cerebral palsied child an oppor-
15 tunity to be completely and fairly assessed, and given
16 help wherever it is necessary to obtain the ultimate of
17 his potential regardless of the degree of his affliction.

18 THE CHAIRMAN: Thank you very much Mr.
19 Nicolson. To do the work which you have set out to do
20 you would naturally require some money. How do you
21 propose to finance?

22 MR. NICOLSON: We propose to have an
23 annual drive similar to the Cerebral Palsy March in
24 the United States, a 53-minute March. There is a cere-
25 bral palsied child born every 53 minutes, and they have
26 a 53-minute March. Service clubs have also told us they
27 will back us.

28 THE CHAIRMAN: You have some assurance
29 that they will back some of the cost?

30 MR. NICOLSON: Definitely. I would like
to mention one thing about the St. Boniface Sanatorium.
The St. Amand Ward. It is administered by the Sisters

more beneficial than that of the child's home. Also, the child would become part of the community of which it is his right, and he would also be receiving his mother's love and that of his entire family.

It is on this fact that we have committed ourselves as the General Policy of Manitoba to make every effort to help these children carry their responsibilities across. Organizations in the United States have proven that multiple handicapped severely retarded children can be helped a great deal. It is the objective of the General Policy of Manitoba to give every retarded child the best of help whenever it is necessary to obtain the best of his potential regardless of the nature of his condition.

THE CHAIRMAN: Thank you very much for that. To do the work which you have set out to do you would naturally require some money. How do you propose to finance it?

MR. DISNEY: As proposed to have an annual drive similar to the General Policy March in the United States, a 30-minute March. There is a considerable number of children in the province, and they have a 30-minute March. Service clubs have also told us they will back us.

THE CHAIRMAN: You have some assistance

that they will back some of the costs.

MR. WILSON: Definitely. I would like

to mention one thing about the St. Boniface Hospital. The St. Anne's Hospital. It is administered by the Sisters.



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4 that were just here, and in discussing this with Dr.
5 Perlstein in Chicago, who is the top authority in the
6 world on cerebral palsy, he stated the fact that our
7 institution here is ten years ahead of anything in the
8 United States, run by the Sisters here.

9 THE CHAIRMAN: You say you would like to
10 have it in this part of the ward. I take it that you
11 must be looking forward to some mutual arrangement to
12 achieve this?

13 MR. NICOLSON: Yes, I think it would be
14 better for the child ---

15 THE CHAIRMAN: I mean the obtaining of
16 the premises?

17 MR. DUREAULT: Subject to arrangements
18 being worked out, the Medical Advisor on the staff of
19 this Association, Dr. Cowell, we understand does some
20 voluntary work at the St. Amand Ward over there.

21 THE CHAIRMAN: What would be the involve-
22 ment of government by way of finance in this?

23 MR. NICOLSON: Well, we would like to set
24 up a day centre under the Department of Education, and
25 get a grant similar to the retarded children's grant,
26 to assist these children and to help pay for the
27 teachers. We have the transportation promised, but the
28 education grant would help that part, and a rehabilita-
29 tion grant, if it was all set up it would help alleviate
30 the cost of the staff, the medical people, the physio-
therapists, and so on.

THE CHAIRMAN: Thank you Mr. Dureault and
Mr. Nicolson. You have set yourselves to a task that



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3 everybody is going to wish you well in, and the submis-
4 sion you have made will receive the careful consideration
5 of this Commission.

6 MR. DUREAULT: May I just point out, Mr.
7 Chairman, that this organization does not intend to do
8 any overlapping of services. It merely wants to fill a
9 gap that other organizations, by reason of their very
10 nature, are unable to fulfill. I understand that three
11 parallel organizations exist in the United States, whereas
12 here, up to this time there has been no cerebral palsy
13 organization to take care of these patients that were
14 left out of the others.

15 THE CHAIRMAN: Thank you very much gentle-
16 men.

17 The brief of the Manitoba Cancer Treatment
18 and Research Foundation.

19 Now, gentlemen, we welcome you here now.
20 We know it is late and you have waited, and we are
21 obliged to you for making yourself available at this
22 time.

23 THE SECRETARY: Sir, this will be known
24 as Exhibit 74.

25 --- EXHIBIT NO. 74: Submission of The Manitoba Cancer
26 Treatment and Research Foundation.
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everybody is going to wish you well in, and the admission you have made will receive the careful consideration of this Commission.

MR. TRENKLE: Now I just point out, Mr.

Chairman, that this organization does not intend to do any overlapping of services. It merely wants to fill a gap that other organizations, by reason of their very nature, are unable to fill. I understand that there are parallel organizations exist in the United States, whereas here, up to this time there has been no concerted organization to take care of these patients that were left out of the others.

THE CHAIRMAN: Thank you very much gentlemen.

men.

The board of the Memorial Cancer Treatment

and Research Foundation.

Now, gentlemen, we welcome you here now.

We know it is late and you have waited, and we are obliged to you for making yourself available at this

time.

THE SECRETARY: Sir, this will be known

as Exhibit 44.

--- EXHIBIT NO. 44: Submission of the Memorial Cancer Treatment and Research Foundation.



SUBMISSION OF THE MANITOBA CANCER TREATMENT AND
RESEARCH FOUNDATION

Appearances: Mr. J.E. Morrison
Mr. C.A. Campbell
Dr. M. MacCharles
Dr. W.R.J. Walton
Mr. T. Steen

MR. MORRISON: Mr. Chairman and members of the Commission, it is my privilege to introduce my associates from the Foundation. On my immediate left is Mr. Campbell, Director of the Foundation and President of the Manitoba Branch of the Canadian Cancer Society. On his left is Dr. MacCharles, physician and surgeon, Director of the Foundation and Director of the Cancer Society of Canada. On his left is Dr. Walton, who is the Executive Director of the Manitoba Cancer Foundation. On his left is Mr. Steen, Comptroller of the Foundation.

Gentlemen, I recognize the lateness of the hour. Our brief has one thing to commend it. It is very brief. I am going to very quickly introduce it, if I may, by saying that it has two principal purposes. First to support the brief previously submitted to you by the Minister of Health, the Honorable George Johnson and his reference to the Foundation in that brief and the recommendations of Dr. Johnson with respect to the financing and the need for increased Federal support of the province and the Foundation, and the financing of its affairs; and secondly, to clarify and to tell you something of the respective roles of the two major organizations concerned with the cancer control problems in the Province of Manitoba.

I should now like to ask Dr. Walton,

Mr. C.A. Campbell
Dr. M. MacPherson
Dr. W.R.J. Walton

MR. ROBERTSON: Mr. Chairman and members

of the Commission, it is my privilege to introduce my
associates from the Foundation. In my immediate left
is Mr. Campbell, Director of the Foundation and President
of the Manitoba branch of the Canadian Cancer Society.
On his left is Dr. MacPherson, physician and surgeon,
Director of the Foundation and Director of the Cancer
Society of Canada. On his left is Mr. Walton, who is
the Executive Director of the Manitoba Cancer Foundation.
On his left is Mr. Brown, Controller of the Foundation.

Continued, I recognize the lateness of

the hour. Our brief has one thing to commend it. It
is very brief. I am going to very quickly introduce it,
if I may, by saying that it has two principal purposes.
First to support the brief previously submitted to you
by the Minister of Health, the honorable George Johnson
and his reference to the Foundation in that brief and
the recommendations of Dr. Johnson with respect to the
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the province and the Foundation, and the financing of
its affairs; and secondly, to clarify and to tell you
something of the respect a roles of the two major

organizations concerned with the cancer control problems

in the Province of Manitoba.

I should now like to ask Dr. Walton,



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3 Executive Director of the Foundation, if he would present
4 this brief.

5 DR. WALTON: Mr. Chairman and members
6 of the Commission, the Manitoba Cancer Treatment and
7 Research Foundation is an organization incorporated in
8 1957 by Act of the Manitoba Government, a copy of the
9 consolidated Act of Incorporation being attached to
10 this brief as Appendix I. The Foundation succeeded
11 the Cancer Relief and Research Institute which, set up
12 by the Provincial Government in 1930, had gradually
13 expanded its activities, with the advice and co-operation
14 of the medical profession, until by 1957 it had wide
15 responsibilities in the field of cancer control in
16 Manitoba. In that year, the Board of the Institute,
17 having reviewed the national programme of the Canadian
18 Cancer Society was satisfied that it should invite the
19 Society to become active in Manitoba, to collect funds
20 in support of research, patient welfare, and public educa-
21 tion. After discussion with the Minister of Health and
22 Public Welfare, the Manitoba Division of the Society
23 was formed and, at the same time, the Foundation was
24 created to carry on the professional and scientific
25 aspects of the work of the Institute and to maintain
26 overall control of the cancer programme.

27 The present duties of the Foundation
28 include:

29 Research

30 The Foundation encourages the members of
its staff and others interested in the cancer problem
to undertake individual research projects, lending



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3 technical assistance where necessary. Fuller partici-
4 pation by the Foundation has, in the past, been hampered
5 by lack of proper facilities, but in its new building,
6 currently under construction, there will be research
7 laboratories to house medical scientists working on a
8 programme closely integrated with the Foundation's
9 clinical activities.

10 Treatment

11 In Manitoba, the surgical treatment of
12 cancer remains in the hands of the members of the medical
13 profession. Essentially all radiation therapy, however,
14 is administered by the staff of the Foundation in Radio-
15 therapy Departments situated in Winnipeg General Hospital
16 and St. Boniface Hospital. The whole cost of operating
17 these services is borne by the Foundation, which also
18 maintains a stock of radium available without charge
19 to qualified physicians and surgeons.

20 Diagnosis

21 The diagnostic responsibilities of the
22 Foundation include consultation with the medical profes-
23 sion at large in the clinical diagnosis and assessment
24 of the extent of disease in cancer patients, and a
25 biopsy service which provides free pathological examina-
26 tion of all tissues removed by rural doctors in their
27 offices. It is hoped to extend this service in the
28 immediate future to patients of Winnipeg doctors.

29 Professional Education

30 The scientific members of the Foundation's
staff hold positions in the Faculty of Medicine, Univer-
sity of Manitoba, and on the staffs of Winnipeg hospitals.



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4 Through these appointments, the Foundation carries out
5 a large programme of professional education in the
6 medical, nursing, and technical fields.

7 Records and Statistics

8 Cancer being a notifiable disease in
9 Manitoba, the Foundation, by arrangement with the Depart-
10 ment of Health, keeps continuous records of all cancer
11 patients in the province. It also prepares and maintains
12 detailed cancer summaries for the two main teaching
13 hospitals.

14 Radioactive Isotope Service

15 By arrangement with Winnipeg General
16 Hospital and St. Boniface Hospital, and with the approval
17 of the Minister of Health and Public Welfare, a radio-
18 active isotope service covering all aspects of research,
19 diagnosis, and therapy, is conducted in both hospitals.

20 Provincial Radiation Protection Service

21 At the request of the Minister of Health
22 and Public Welfare, the Foundation operates a radiation
23 protection service across the province involving the
24 calibration, at regular intervals, of all radiation
25 emitting equipment and substances, and the recommendation
26 of modifications where necessary.

27 A film badge service, covering all exposed
28 personnel in the province, is administered by arrangement
29 with the Federal Department of Health and Welfare.

30 Funds to support the operation of the
Foundation come from two sources:

1. Federal and Provincial funds, through
the Matching Cancer Grants, and through

Through these appointments, the Foundation carries out

medical, nursing, and technical fields,

Records and Statistics

Cancer being a notifiable disease in

Manitoba, the Foundation, by arrangement with the Depart-

ment of Health, keeps continuous records of all cancer

patients in the province. It also organizes and maintains

detailed cancer registries for the two main teaching

hospitals.

Radiation Protection Service

By arrangement with Winnipeg General

Hospital and St. Boniface Hospital, and with the approval

of the Minister of Health and Social Welfare, a radio-

active service covering all aspects of research,

diagnosis, and therapy, is conducted in both hospitals.

Provincial Radiation Protection Service

At the request of the Minister of Health

and Public Welfare, the Foundation operates a radiation

protection service for the province involving the

collaboration, at regular intervals, of all radiation

existing agencies, and the recommendation

of modifications where necessary.

Additional large activities covering all exposed

personnel in the province, is a maintained by an agreement

with the Federal Department of Health and Welfare.

Funds to support the operation of the

Foundation come from two sources

1. Federal and Provincial Funds, through



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3 the Manitoba Hospital Services Plan.

4 2. Funds voluntarily subscribed either
5 directly or through the Canadian Cancer
6 Society and the National Cancer Institute
7 of Canada.

8 The therapeutic, diagnostic, educational,
9 and statistical activities of the Foundation are suppor-
10 ted entirely by government monies, while its research
11 activities are supported from both sources, in that
12 senior staff members have their salaries paid from
13 government funds, while equipment, supplies, and the
14 salaries of technicians engaged in research are provided
15 by the Canadian Cancer Society through the National
16 Cancer Institute of Canada.

17 The Foundation understands that the
18 Canadian Cancer Society is submitting its own brief to
19 the Royal Commission on Health Services. Nevertheless,
20 it wishes to emphasize the great importance that public
21 participation, through voluntary contribution, has
22 played in the field of cancer control. In this province,
23 patient welfare and public education are both supported
24 entirely from this source, while, nationally, more than
25 80% of all the money available for cancer research comes
26 from the annual campaigns of the Canadian Cancer Society.

27 In its efforts to provide the best
28 possible cancer services to an expanding population,
29 the Foundation has received diminishing support from
30 the Federal share of Cancer Grants, although additional
Federal support has been forthcoming since the inception
of the Manitoba Hospital Services Plan, in respect of

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3 radiotherapy services to in-patients. As a result, an
4 increasing proportion of the load continues to fall
5 on the Manitoba Government. It is the hope of the Founda-
6 tion that support from Federal and Provincial sources
7 will continue in such a way as to encourage increased
8 direct participation of the public and considers that this
9 can best be done by expanding the Federal portion of
10 the Cancer Grants.

11 In reviewing its programme, the Foundation
12 feels that it is a sound one. It anticipates that
13 improvements will follow occupancy of the new building
14 where there will be better facilities for the care of
15 patients and improved equipment for their treatment.

16 Finally, it wishes to point out that
17 there exists an urgent need in Winnipeg for "hostel"
18 type accommodation for country patients requiring radia-
19 tion therapy. At the present time these patients must
20 either occupy "acute" hospital beds or be housed in
21 unsatisfactory boarding houses in the vicinity of the
22 treatment centres.

23 THE CHAIRMAN: Do any of you gentlemen
24 have any comments to make, that you wish to add to what
25 Dr. Walton has just read?

26 MR. MORRISON: Mr. Chairman, I might make
27 the further observation regarding the question of
28 Federal grants that it is probably well known to you all,
29 that those grants have remained for the whole of Canada
30 stationary at \$3,000,000 for three years now, and the
province's share is based entirely on the proportion of
our population to the whole of Canada, and that is why

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increasing proportion of the total continues to fall

on the Manitoba Government. It is the hope of the foundation

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type accommodation for convalescent patients requiring radio-

therapy. At the present time these patients must

either occupy "acute" hospital beds or be housed in

unsatisfactory boarding houses in the vicinity of the

THE CHAIRMAN: To any of you gentlemen

have any comments to make, that you wish to add to what

Dr. Walton has just said?

MR. MCLELLAN: Mr. Chairman, I might make

the further observation regarding the question of

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that those grants have remained for the whole of Canada

stationary at \$2,000,000 for three years now, and the

province's share is based entirely on the population of

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3 these grants have gone down in relation to Manitoba
4 because our population has not kept pace with the rest
5 of the country. So, while our needs have increased in
6 the past years, the grants have been going down, and the
7 Provincial Government has of course had difficulty, and
8 we have now this new building, which is getting on its
9 way to completion here in Manitoba, which will be one
10 of the finest treatment centres, we believe, on this
11 continent, for this treatment of cancer, and we will
12 have increasing needs as we look to the future, and an
13 increased need for further support from Federal resources.

14 THE CHAIRMAN: Do you wish to add anything,
15 Mr. Campbell?

16 MR. CAMPBELL: I don't think I can add
17 anything right at the present time. The Canadian Cancer
18 Society hopes to contribute more to the research projects
19 of the Foundation when the building is finished, and they
20 have their personnel set up, and we are looking forward
21 to having one of the finest research projects in the
22 country.

23 COMMISSIONER BALTZAN: Gentlemen, what
24 are your physical facilities here? Have you got a
25 cancer centre building of your own?

26 DR. WALTON: At the present time, sir,
27 we have a very scattered operation. We have radiotherapy
28 centres in the Winnipeg General Hospital and the St.
29 Boniface Hospital. We have a Physics Department in one
30 part of the city, business offices in another part of
Winnipeg General Hospital. In the new building currently
under construction, all these activities will be brought

these grants have gone down in relation to Manitoba because our population has not kept pace with the rest of the country. So, while our needs have increased in the past years, the grants have been going down, and the Provincial Government has of course had difficulty, and we have now this new building, which is getting on its way to completion here in London, which will be one of the finest treatment centres, we believe, on this continent, for this treatment of cancer, and we will have increasing needs as we look to the future, and an increasing need for further support from Federal resources. THE CHAIRMAN: Do you wish to add anything?

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part of the city, business offices in another part of

Winnipeg General Hospital. In the new building currently

under construction, all these activities will be brought



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4 under one roof, with the exception of a radiotherapy
5 department in St. Boniface Hospital, which will continue
6 as a separate operation.

7 COMMISSIONER BALTZAN: How do you carry
8 on your diagnostic operation, do physicians refer them
9 to you?

10 DR. WALTON: In most cases they are
11 submitted. We do not operate a full-scale diagnostic
12 service as is the case perhaps in Saskatchewan.

13 COMMISSIONER BALTZAN: Can you have full
14 records made up of the number of cases that are diagnosed,
15 treated, etc., in this manner?

16 DR. WALTON: Yes, we keep full records.
17 We have done so since 1930.

18 COMMISSIONER BALTZAN: Physicians' reports
19 you mean?

20 DR. WALTON: Yes.
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4 COMMISSIONER STRACHAN: Is your new
5 centre near the Winnipeg General or attached to it?

6 MR. MORRISON: Yes sir, it is adjacent to
7 it.

8 COMMISSIONER McCUTCHEON: How many beds
9 would it have?

10 MR. MORRISON: We have no beds.

11 COMMISSIONER McCUTCHEON: Would you
12 continue your radiotherapy at the Winnipeg General?

13 DR. WALTON: We make use of the hospital
14 beds in the Winnipeg General and the St. Boniface.

15 COMMISSIONER McCUTCHEON: You do now?

16 DR. WALTON: Yes.

17 COMMISSIONER VAN WART: Do cancer patients
18 pay anything at all along the line?

19 DR. WALTON: Not for radiotherapy. The
20 surgical treatment for cancer is treated in Manitoba in
21 the same way as surgical treatment for any other disease.
22 The radiation treatment is free to all residents of
23 Manitoba. A nominal charge is made for non-residents.

24 COMMISSIONER VAN WART: Do you mean for
25 every case?

26 DR. WALTON: It is assessed on the length
27 and complexity of the course of treatment, and the fees
28 run from \$15 to \$65 for a course of treatment.

29 COMMISSIONER VAN WART: That is every
30 patient?

DR. WALTON: Every patient not a resident
of Manitoba.

THE CHAIRMAN: Is this a service covered



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centre near the Winnipeg General or attached to it?

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DR. WALTON: Every patient not a resident

of Manitoba.

THE CHAIRMAN: Is this a service covered



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3 by the M.M.S.?

4 DR. WALTON: No.

5 THE CHAIRMAN: The physician's charge?

6 DR. WALTON: No, this charge is levied
7 by the Foundation, and covers the cost of the use of
8 its premises and machinery.

9 THE CHAIRMAN: That is for out of Manitoba
10 patients, but I am talking about medical treatment and
11 surgical treatment for cancer: is that one of the
12 insurable items under M.M.S.?

13 DR. WALTON: Wherever the physician is
14 involved, it is covered, and wherever it is an institution
15 involved it is not covered.

16 COMMISSIONER VAN WART: The charge for
17 the out of Manitoba patients comes to the hospital or
18 your organization?

19 DR. WALTON: To the Foundation.

20 THE CHAIRMAN: And the patient in hospital
21 is covered by the hospitalization plan?

22 DR. WALTON: That is correct.

23 COMMISSIONER McCUTCHEON: The hospitaliza-
24 tion plan does not cover out-patient radiotherapy?

25 DR. WALTON: No, sir.

26 COMMISSIONER McCUTCHEON: It is permissible
27 under the Federal Government's rules to cover that -- it
28 is, isn't it?

29 DR. WALTON: Yes.

30 COMMISSIONER McCUTCHEON: It is for the
province it is not covered?

DR. WALTON: That is correct.



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4 THE CHAIRMAN: Thank you, gentlemen,
5 and thank you again for your accommodating us and
6 being here at this time.

7 SUBMISSION OF THE AMBULANCE OPERATORS' ASSOCIATION

8 Appearances: Mr. W.R. Christensen
9 Mr. D.R. Irish

10 --- EXHIBIT NO. 75: Submission of the Ambulance Opera-
11 tors' Association.

12 THE CHAIRMAN: Mr. Christensen?

13 MR. CHRISTENSEN: Yes, Mr. Chairman.

14 This is Mr. Irish with me, one of the proprietors of
15 one of the services.

16 It is with respect that this brief is
17 presented to you on behalf of the above-mentioned
18 ambulance firms, in the belief that as you consider all
19 aspects of health services and the resources available
20 to meet the needs of the Canadian people, that ambulance
21 services will be one of the concerns of this Commission.

22 The firms on whose behalf this brief is
23 presented are aware of the fact that their services are
24 needed promptly. It is felt that although inadequacies
25 exist in their operations, that they, as individuals,
26 are unable to overcome these difficulties with which they
27 are confronted. Provincial legislation is urged to
28 ensure a more complete service to the public. The legis-
29 lation requested is of a regulatory nature and not a
30 request for Government control and operation. The work
can be done by private enterprise such as the present



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3 firms which are providing adequate service for this
4 area. It is to the credit of many firms that they main-
5 tain the standard of service that they do, realizing
6 that their service is a public need as well as a means
7 of livelihood. The operation of an ambulance service
8 is an expensive undertaking, requiring trained personnel.
9 It is not suggested here that elaborate ambulances with
10 attendant doctors or interns are a necessity for good
11 service but we are requesting that adequate standards
12 be established to maintain a minimum degree of control,
13 consonant with a maximum efficiency and care.

14 The operation of ambulance service in
15 Manitoba is remarkable as one considers the almost
16 complete absence of governing legislation. It should be
17 noted that in the field of health services, most aspects
18 are governed by comprehensive legislation with the
19 exception of ambulance services. No province in Canada
20 has any statute governing this service. Uniform stan-
21 dards can only be provided by provincial legislation.
22 Municipal by-laws as shown by examples discussed in
23 Section C, show that even within one province there is
24 a variation as to requirements. It is, therefore,
25 suggested that a provincial statute would overcome
26 conflicting by-laws and assure the public of uniform
27 service.

28 This brief will deal primarily with two
29 aspects of ambulance service; standards and fees.

30 Before proceeding into the recommendations,
I might point out that in the City of Winnipeg there are
six ambulance firms operating. This brief is being



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3 presented on behalf of three. All six gathered at one
4 time a while ago to discuss these matters, and the
5 three that are not represented by this brief decided
6 they would rather wait and see what the Commission
7 itself did about ambulance services, rather than putting
8 forth recommendations on their own.

9 RECOMMENDATIONS

10 1. Provincial legislation should be
11 enacted to provide for a standard of

- 12 (a) Education and training of personnel,
13 (b) Equipment required,
14 (c) Type of vehicle,
15 (d) Liability insurance.

16 2. A Board of Control should be created
17 and be empowered to license and regulate all ambulance
18 firms in Manitoba, in order to assure the public of
19 uniform licensing requirements.

20 3. It is further recommended that rates
21 charged by these firms be set by the above-mentioned
22 Board and that consideration be given to the inclusion
23 of ambulance fees in the Manitoba Hospital Services
24 premiums or some other fund to be created so that all
25 who need the service will know it is available to them
26 and ambulance firms will know that they can meet their
27 expenses.

28 4. In the metropolitan area of Greater
29 Winnipeg, areas of responsibility for emergency calls
30 should be assigned to each firm in order that the firm
located closest to the place of need will be called by
the police or through the 999 service.

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THE CHAIRMAN: Thank you, Mr. Christensen.
It is perhaps well that at least three of the organiza-
tions saw fit to give the matter consideration because,
as you can appreciate, if those who are likely interested
in a particular problem do not come forward with their
ideas and their suggestions, then the Commission may get
the suggestions from others who may not know anything
about the business concerned.

MR. CHRISTENSEN: Or have a different
point of view.

THE CHAIRMAN: Yes. Have you any air
ambulance in Manitoba?

MR. CHRISTENSEN: No, we haven't, sir,
except through the R.C.A.F.

COMMISSIONER GIRARD: May I ask this:
who rides in the ambulance -- first aid men, internes...?

MR. CHRISTENSEN: This is dependent on
where you are located. In Winnipeg, at the present
time, the only by-law that governs this area is one
which requires the attendant, the driver and the owner
or proprietor of the ambulance service to have a first
class St. John's Ambulance certificate; that is the
first one -- not a senior certificate or anything like
that; and, generally speaking, two people do go in with
it, although there is no requirement as to this by the
licensing board.

THE CHAIRMAN: You are suggesting some
form of board for the control of licensing?

MR. CHRISTENSEN: Yes, sir.

THE CHAIRMAN: If a separate board could



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3 not be forthcoming, could it be handled through the
4 Board which issues motor licences now?

5 MR. CHRISTENSEN: I believe in Manitoba
6 there is a taxi board.

7 THE CHAIRMAN: There is a taxi board,
8 yes.

9 MR. CHRISTENSEN: Yes, governing the
10 licences issued and so forth, and I think it could
11 quite adequately be handled through that once it is set
up.

12 THE CHAIRMAN: Rather than have a multipli-
13 city of boards?

14 MR. CHRISTENSEN: Yes, I think we have
15 enough boards.

16 COMMISSIONER McCUTCHEON: That board is
17 a rate-making board now?

18 MR. CHRISTENSEN: Yes, it assesses the
19 rates for the taxis.

20 THE CHAIRMAN: Thank you, gentlemen. As
21 I said, it is desirable and helpful that you should have
22 taken the pains to submit this brief, and it will have
our consideration.

23 MR. CHRISTENSEN: Thank you very much, sir.

24 THE CHAIRMAN: We will now adjourn until
25 9 o'clock tomorrow morning.

26 --- Adjournment.
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ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

WINNIPEG

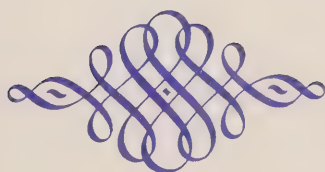
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VOLUME 16

I N D E X.

Page No

THE MANITOBA CHAMBERS OF
COMMERCE

3831

THE SENIOR CITIZENS' FEDERATION
OF MANITOBA

3853



ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearing
held in Winnipeg, Manitoba,
19th day of January, 1962.

COMMISSION MEMBERS

CHIEF JUSTICE EMMETT M. HALL ----- Chairman

MISS ALICE GIRARD, R.N.

DR. DAVID M. BALTZAN

PROF. O. J. FIRESTONE

MR. M. WALLACE McCUTCHEON, Q.C.

DR. C. L. STRACHAN

DR. ARTHUR F. VAN WART

COMMISSION COUNSEL:

MR. R. N. HALL, Q.C.

MEDICAL CONSULTANT:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

SECRETARY:

MAJ. N. LAFRANCE



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Proceedings of the hearing
held in Winnipeg, Manitoba,
15th day of January, 1962.

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MR. M. WALLACE MCCUTCHEN, Q.C.
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MAL. N. LAFRANCE



Winnipeg, Manitoba,
Friday,
January 19th, 1962.

3831

---On commencing at 9:00 a.m.

THE CHAIRMAN: We will start this morning
with the submission of the Manitoba Chambers of Commerce.

THE SECRETARY: That will be exhibit
number 76.

---EXHIBIT NO. 76: Submission of the
Manitoba Chambers of
Commerce.

SUBMISSION OF

THE MANITOBA CHAMBERS OF COMMERCE

APPEARANCES:

N. M. ZUNIC, Esq.	President
MR. F. W. EVANS	Vice-President
MR. ROD H. THOMSON	Manager

MR. EVANS: Mr. Chairman, we represent
124 Chambers of Commerce across the province.

The Manitoba Chambers of Commerce believe
that the Governments, both Federal and Provincial have well
defined responsibilities for the institution of programs
for the prevention of diseases, for the cure and rehabili-
tation of those suffering long term illness and for the
care of the chronically ill, the incurable and the aged.

The Chambers further recognize the
responsibility of society to help those individuals
incapable of providing for themselves. It is our feeling
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4 medical care should not be predicated upon the assumption
5 that the majority of the people are incapable of providing
6 for their own.

7 Programs for the provision of the services
8 aforementioned should be confined exclusively to those
9 areas suggested and should be paid for directly from the
10 general taxation revenue of the respective governments.

11 The imposition of compulsory fees or
12 premiums on the nation as a whole without regard to the
13 individuals rights and responsibilities, without regard
14 to provision of a choice by the individual as to whether
15 he wishes to participate or not may be an infringement on his
16 rights, which we so jealously guard under our democratic
17 system.

18 The Chambers sincerely feel that the removal
19 of responsibility from the individual to provide for
20 himself, destroys incentive and weakens self-reliance.

21 The Chambers feel that all should be
22 cautious in their approach to this problem. It has become
23 increasingly prevalent in our society to justify compulsion
24 and arbitrary actions in the guise of being for the good
25 of the public welfare. We would ask that this Commission
26 examine all factors including the indirect effect that
27 may be felt by the nation, should we continue to impose
28 compulsory programs for the provision of services,
29 normally considered a part of our individual responsibility.

30 THE CHAIRMAN: Mr. Evans, I did not quite
catch the number of bodies you said you represent here
this morning.

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3 represent the 124 chambers.

4 THE CHAIRMAN: And what membership does
5 that involve?

6 MR. EVANS: 11,000, somewhere around there.

7 THE CHAIRMAN: And your representation, is
8 that distributed quite broadly across the province?

9 MR. EVANS: Yes, it is fairly well distri-
10 buted according the rural population throughout the whole
11 province north as far as Churchill and down south to the
12 border.

13 THE CHAIRMAN: And from this broad repre-
14 sentation, broad coverage of the province, are you in a
15 position to give the Commission any information, any views
16 as to the extent to which or the extent of lack of medical
17 services in the rural part of Manitoba?

18 MR. EVANS: Well, we have not had an
19 opportunity to make a specialized study of such a subject.
20 We have, however, conducted recently this Fall in October,
21 November and December, twelve area meetings throughout the
22 whole of Manitoba at which most of these various local
23 chambers have sent representation. This matter of health
24 services has been, in many cases, the subject under dis-
25 cussion at these meetings and our submission today is
26 the general opinion of the representations from most of
27 the chambers in the way in which we have it worded.

28 THE CHAIRMAN: Have you sensed in your
29 area meetings throughout the province any indication that
30 there are people in Manitoba who are suffering for want
of medical attention?

MR. EVANS: I will turn to Mr. Zunic, our

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4 answer.

5 MR. ZUNIC: To some degree in areas where
6 hospital facilities are not up to average standard in
7 the province, doctors reluctant to serve the remote areas
8 of the province, there is very little dental care and
9 other medical services. This is true in areas between
10 the lakes in Manitoba and in the remote north.

11 THE CHAIRMAN: Now, have you any suggestions
12 as to how that situation might reasonably be remedied?

13 MR. ZUNIC: This is a feeling of a few of
14 us, perhaps not the majority in the organization, that a
15 division of the province be undertaken for medical
16 services to provide better hospital facilities and thereby
17 attract more doctors to serve in this area. It should be
18 set up somewhat similar, for the purpose of taxation,
19 support, building et cetera to what a high school system
20 is now set up. Something of that nature might be helpful.

21 THE CHAIRMAN: Are you developing a cen-
22 tralized high school system in Manitoba?

23 MR. ZUNIC: Yes, and if something of this
24 nature was done with hospitals there would be a greater
25 area on which to draw for taxation purposes, if you like,
26 and support in order to make it possible economically to
27 build and support these buildings and services.

28 THE CHAIRMAN: You suggest they be based
29 on municipal government? I mean, when you are talking
30 about taxation purposes you mean local taxation purposes?

MR. ZUNIC: Yes, but each division or
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4 THE CHAIRMAN: But does this express your
5 view that the areas where there is want of care that it
6 is because of their geographic location rather than
7 economics?

8 MR. ZUNIC: Not entirely. There are sections
9 of the province that are poor economically, their earnings
10 are low and the yield from the land is low and these
11 sections require some assistance.

12 THE CHAIRMAN: Under what form do you say
13 that assistance should come?

14 MR. ZUNIC: Well, assuming that the larger
15 areas are established and the service is brought to them
16 rather than them being brought in to the service.

17 THE CHAIRMAN: That would be in hospitaliza-
18 tion but what about medical and dental and drug costs and
19 so forth?

20 MR. ZUNIC: We make it fairly clear, I
21 think, that in areas where it is beyond the economic
22 ability of the individual to look after himself that the
23 state look after him through general revenue.

24 THE CHAIRMAN: And you do not like the
25 idea of a premium?

26 MR. ZUNIC: No.

27 THE CHAIRMAN: You would not favour a
28 premium at all?

29 MR. ZUNIC: Well, we would not favour a
30 compulsory premium.

COMMISSIONER FIRESTONE: Perhaps I might
follow on in the same vein as the Chairman has been



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COMMISSIONER FERGUSON: Perhaps I might

follow on in the same vein as the Chairman has been



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4 questioning you. Are you in favour, as the Manitoba
5 Chambers of Commerce, of a prepaid medical care programme
6 available to all people in the province of Manitoba?

7 MR. EVANS: Only for those individuals
8 incapable of providing for themselves.

9 COMMISSIONER FIRESTONE: Are you in favour
10 of the principle of prepaid medical care?

11 MR. EVANS: As long as it is voluntary.

12 COMMISSIONER FIRESTONE: You are in favour
13 of a programme of prepaid medical care on a voluntary
14 basis for all residents of the province of Manitoba?

15 MR. EVANS: As if it was any other form
16 of insurance and prepaid medical care would be a form of
17 insurance, health insurance. As long as it is voluntary
18 we would be for it.

19 COMMISSIONER FIRESTONE: As you realize,
20 such a universally available medical care plan has to be
21 financed and paid for. Would you feel that those that
22 can pay the premiums that are required to support such a
23 scheme like an insurance premium pay for this?

24 MR. EVANS: Those that can afford it and
25 as long as it is done on a purely voluntary basis. In
26 other words, the whole membership through the prepaid
27 medical care and the availability of it on the basis of
28 a purely voluntary support the same as any independent
29 insurance system. I think, as we point out in our brief,
30 that we recommend it is the responsibility of society to
provide for those incapable of providing for themselves.

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5 can afford to pay the premium are required to maintain
6 their contribution to such a scheme?

7 MR. EVANS: Yes, those who are able to do
8 so should do so.

9 COMMISSIONER FIRESTONE: Now, those who are
10 unable to pay the premium for economic or other reasons,
11 you would be in favour of that premium either in part or
12 in full being paid by the state?

13 MR. EVANS: Yes, sir.

14 COMMISSIONER FIRESTONE: If the Federal
15 Government or the Provincial Government of Manitoba or
16 both the Federal Government and the Provincial Government
17 were to decide to establish an advisory council on health
18 care would the Manitoba Chambers of Commerce support the
19 establishment of such an advisory council on health care?

20 MR. EVANS: Yes, I feel certain that they
21 would because the Chambers' policy is to support such
22 government projects.

23 COMMISSIONER FIRESTONE: And if asked to
24 would participate and nominate members representing the
25 Manitoba Chambers of Commerce on such a Board in order to
26 offer new advice on the development of a reasonably sound
27 satisfactory health care for the province of Manitoba?

28 MR. EVANS: The Chambers would be glad to
29 do so.

30 THE CHAIRMAN: Arising out of one of Dr.
Firestone's questions and your answer; you refer to that
class, that group described as not being able to pay
premiums. How would you identify that group?

MR. ZUNIC: If I may. This is a difficult

question? Do I take it from what you said that those who can afford to pay the premium are required to maintain their contribution to such a scheme?

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unable to pay the premium for economic or other reasons, you would be in favour of that premium either in part or in full being paid by the state?

COMMISSIONER FIRESTONE: In the Federal

Government or the Provincial Government of Manitoba or both the Federal Government and the Provincial Government were to decide to establish an advisory council on health care would the Manitoba Chambers of Commerce support the establishment of such an advisory council on health care? MR. EVANS: Yes, I feel certain that they

would because the Chambers' policy is to support such

COMMISSIONER FIRESTONE: and if asked to

would participate and nominate members representing the Manitoba Chambers of Commerce on such a board in order to offer new advice on the development of a reasonably sound satisfactory health care for the province of Manitoba?

MR. EVANS: The Chambers would be glad to

do so.

THE CHAIRMAN: Arising out of one of Dr.

Firestone's questions and your answer; you refer to that class, that group described as not being able to pay

premiums. How would you identify that group?

MR. EVANS: If I may, this is a difficult



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3 question to answer and we are aware that perhaps half the
4 people in Manitoba are protected now by their own choice
5 to do so. There is a section of the population of the
6 province which is unable to provide this service by them-
7 selves and pay premiums and there is a section which could
8 but does not. Without suggesting that we check on the
9 individual's earning power annually and wondering if he
10 fritters his money away rather than looking after him-
11 self -- this is difficult to do, difficult to answer and
12 I might suggest that this area does not need legislation
13 but perhaps education and instruction of individual's
14 responsibilities which we are stressing to some degree
15 now. I have not answered your question but I have attempted
16 to point out the difficulties in answering.

16 THE CHAIRMAN: You see, practically every-
17 body who has been before us has taken the same view that
18 you gentlemen take and the Manitoba Chambers of Commerce
19 take, that there is a group -- actually we have three
20 groups, we have the group that is able to pay their own
21 premiums; you have the group that just cannot pay it and
22 then there is the area in between. As to that area there
23 seems to be common agreement that there should be govern-
24 mental assistance.

25 MR. ZUNIC: So that they should be com-
26 pelled, perhaps.

27 THE CHAIRMAN: What do you mean "compelled"?

28 MR. ZUNIC: If a plan was developed that
29 those who do not, because of their own lack of respon-
30 sibility to themselves, if you wish, do not provide for
the future in this area of health services, some have

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4 suggested this area be compelled to do so.

5 THE CHAIRMAN: Would you advocate that?

6 MR. ZUNIC: No, I would not. I really feel
7 it is a matter of instruction and education rather than
8 legislation and compulsion.

9 THE CHAIRMAN: I might have misunderstood
10 you but I thought you mentioned a while back that there
11 were areas in the province where the productivity of the
12 land was such that the income which is earned there ----?

13 MR. ZUNIC: There are, yes.

14 THE CHAIRMAN: How does education or what-
15 ever you want to do increase the economic output of an
16 area which has not got the capacity?

17 MR. ZUNIC: Well, in this area I suggest
18 assistance to people from general revenue of the nation.

19 THE CHAIRMAN: Would you do it territorially
20 rather than on the basis of persons or families?

21 MR. ZUNIC: Territorially may be more
22 easily administered.

23 THE CHAIRMAN: I am just asking you if you
24 would do it that way.

25 MR. ZUNIC: Perhaps. I really cannot answer
26 this, it is a future thing.

27 THE CHAIRMAN: No, but you see gentlemen,
28 the answer has to be forthcoming some place and you
29 gentlemen who represent such a broad base of rural
30 Manitoba, we are seriously putting the question to you.

MR. ZUNIC: Well, we are not able to answer
with reference to this investigation or this discussion
only because other aspects of rural economy enter into
the picture; industrialization, changes in farming methods

suggested this area be compelled to do so.

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4 THE CHAIRMAN: But take your inner lake
5 region, your northern areas.

6 MR. ZUNIC: We believe that that area can
7 be developed over the years economically to support it-
8 self. Now we are attempting to answer in the light of
9 present circumstances. There are one or two other of
10 these factors that have to be discussed.
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4 MR. EVANS: Your Honour, may I suggest that
5 even in some of the depressed areas in Manitoba a great
6 depends on just how high a premium would be set. It is
7 very doubtful in my mind, and I am speaking personally for
8 a moment.

9 THE CHAIRMAN: Well, it is suggested that
10 the premium is in the order of one hundred to one hundred
11 and fifteens dollars.

12 MR. EVANS: Per person?

13 THE CHAIRMAN: No, per family.

14 MR. EVANS: Well, that is a guide for us
15 in answering your question, and I do sincerely feel that
16 there are comparatively few. Now, as to percentage of
17 rural population, that is very difficult to answer without
18 a survey, but there would be a very, very few would be un-
19 able to pay that. Now, there is a number which would be
20 unwilling to pay it voluntarily, because they do not have
21 a sense of responsibility, which of course form another
22 problem, but the number of families who would not be prepared
23 to pay a premium of that nature, one hundred to one hundred
24 and fifteen dollars, would be very, very few indeed, I
25 would suggest in the whole of Manitoba in 1962.

26 COMMISSIONER VAN WART: The analogy was
27 brought out with the school system. Do all children in
28 this area between the lakes and the north and so on get
29 education?

30 MR. ZUNIC: Yes.

COMMISSIONER VAN WART: Are they transported
to schools, or under what system?

MR. ZUNIC: They are transported to the
central schools.



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4 COMMISSIONER VAN WART: How is that
5 chidren's education financed?

6 MR. ZUNIC: Through both the levy at the
7 local level and provincial assistance by grants.

8 COMMISSIONER VAN WART: You suggested we
9 have hospitals or workshops if you want, for doctors in
10 the area. Would it not be similar to the school and
11 sick children and so on would be transported and so on
12 under a system like that? Is that what you had for an
13 analogy in your mind?

14 MR. ZUNIC: I suggest that a larger
15 hospital area similar to the school area would be more able
16 to support better hospital facilities, clinical and medical
17 facilities, within that area, by virtue of a broader base,
18 rather than having a number of small units. We would have
19 fewer large units. Perhaps this is the most difficult
20 thing to establish within the competition of communities
21 growing and developing. Each would compete for this.
22 It would have to be on a net of highways to serve the
23 area properly, and because of its broader base of support,
24 that is through taxation locally, that would afford a
25 better service locally through larger units, rather than
26 small units as now with no clinical facilities at all,
27 or operating units and so forth.

28 COMMISSIONER VAN WART: That would be
29 predisposed to a transportation system, would it to the
30 hospital?

MR. ZUNIC: Possibly there would be a whole
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4 COMMISSIONER VAN WART: As to the financing
5 of such a system, would you suggest it be financed in a
6 way similar to the way the school system is financed?

7 MR. ZUNIC: For capital construction, yes.
8 For operation, I think this would vary from community to
9 community, or division to division. One would see where a
10 division located in Portage la Prairie; one would be in
11 a better position than one in Aramantha, which is 40 miles
12 north of Portage, and sparsely populated. This would
13 again bring us back to the Chairman's question about
14 support on a regional basis, rather than on an individual
15 basis only.

16 COMMISSIONER VAN WART: In your school
17 system the tax reaches this group the Chairman spoke about,
18 does it no?

19 MR. ZUNIC: Yes, in the school support the
20 taxation aspect reaches all.

21 COMMISSIONER VAN WART: And they have solved
22 this problem of taxation among these lower poor groups?

23 MR. ZUNIC: Well, the ability to pay is
24 based on assessment.

25 THE CHAIRMAN: Yes, but you have very, very
26 substantial government grants, have you not?

27 MR. ZUNIC: Yes.

28 COMMISSIONER VAN WART: Could not this be
29 worked out similarly in paying health in the same district?

30 MR. ZUNIC: Perhaps.

31 COMMISSIONER VAN WART: That does not
32 necessarily mean a premium does it?

33 MR. ZUNIC: No, it does not mean a premium.

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5 another. In some cases they are collected later, and in
6 some cases they are from general revenue.

7 THE CHAIRMAN: To follow the analogy of
8 the school system, are you able to give the percentage
9 figure of provincial grant to local taxation for your
10 composite high school in rural Manitoba?

11 MR. ZUNIC: For capital construction it is
12 about a 30/70 share. 30 from the province, 70 collected.

13 THE CHAIRMAN: In amortization was it as
14 high as 80% from the province?

15 MR. ZUNIC: I don't know, possibly.

16 COMMISSIONER FIRESTONE: If I may follow
17 up this question which you have raised, Mr. Chairman,
18 and ask the gentleman a question. We are trying to learn
19 a little bit more how one can delineate that group that
20 can reasonably be expected to find it difficult to pay
21 this premium we are talking about, one hundred dollars
22 plus or minus a family per year, say eight dollars per
23 month, a little more or a little less, and the group
24 that you would be in favour, as we understand it, that
25 their premium, their contribution be paid out of general
26 revenue, general revenue either coming from the pro-
27 vincial government or the federal government, or both,
28 would you support a plan where the group that would be
29 exempt from the payment of premium would be people that
30 are exempt from paying income tax?

MR. EVANS: That has many things to commend
itself, because it is quite straightforward and you would
know who is who and for want of anything better, on the



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3 spur of the moment I would answer yes.

4 COMMISSIONER FIRESTONE: You realize that
5 there approximately speaking for Canada as a whole one
6 out of three persons working that are in this category,
7 that one out of three do not pay income tax. Two out of
8 three persons work and pay income tax. In other words,
9 if this percentage that is applicable to Canada as a whole
10 were also applicable to Manitoba, it would mean that the
11 premiums of about one-third of Manitoba's population of
12 about 900,000, or 300,000, would have to be paid by the
13 State, the State including Federal and Provincial Govern-
14 ment. Do you feel after having presented these facts,
15 in a very approximate form, because they would have to
16 be verified by our Research staff, but even after you have
17 been given this sort of perspective, you still would
18 support such a plan?

19 MR. EVANS: As I was saying a minute ago,
20 it is a system which has a lot of merit to it, but I still
21 doubt if everybody who is not paying income tax can all
22 be considered to be unable to pay a premium of one hundred
23 to one hundred and fifteen dollars a family for medical
24 insurance, shall we call it, so I wouldn't go along
25 wholeheartedly with you on that, except just as a basis
26 to go on. It could be based on that, but perhaps from
27 there some system could be worked out which would be
28 getting it down more to the basic reality of the people to
29 pay such a premium. I don't think we could set aside all
30 people who are in the income tax non-paying group, and
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5 COMMISSIONER FIRESTONE: In other words,
6 you are in favour of the principle, but you would want
7 to have some experts work on this formula and to bring it
8 down to a realistic basis?

9 MR. EVANS: Yes.

10 COMMISSIONER FIRESTONE: Would the Manitoba
11 Chambers of Commerce support a prepaid dental care pro-
12 gramme?

13 MR. EVANS: Prepaid dental care again, as
14 a basis of insurance which is voluntary, yes, the principle
15 is supported by the Manitoba Chambers.

16 COMMISSIONER FIRESTONE: Would the Manitoba
17 Chambers of Commerce also support a prepaid drug plan?

18 MR. EVANS: I believe any of these pre-
19 paid plans which are a form of insurance, are good things,
20 and from the standpoint of the corporation as a whole,
21 insurance as such is something which the Manitoba Chambers
22 in general are standing behind. They believe in it as a
23 good principle, the principle of insurance is good.

24 COMMISSIONER FIRESTONE: Would you say that
25 such plans should become universally available in the
26 Province of Manitoba?

27 MR. EVANS: Available to all those who
28 wish to participate in them, sir, yes.

29 COMMISSIONER FIRESTONE: Would you say
30 that in implementing a prepaid dental care programme and
a prepaid drug plan, the same principles of payment might
apply as you have suggested for a prepaid medical plan?

MR. EVANS: Yes.

MR. ZUNIC: If I may, Mr. Chairman, answer

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MR. ADAMS: If I may, Mr. Chairman, answer



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4 more fully an earlier question. In our recently held
5 twelve workshops and meetings throughout the
6 province, the question was asked did we find the need
7 for this service. I would like to say that not in any
8 of these was there illustrated an example of people not
9 getting medical service. If they appeared where medical
10 service was available they got it, and there was no
11 question of whether it would be paid for or not. Now,
12 how they managed to operate without being paid I cannot
13 answer, but we had no examples of people being refused
14 medical service.

15 COMMISSIONER BALTZAN: Gentlemen, would
16 you say there are adequate health facilities in your
17 Province to satisfy the demand for it?

18 MR. EVANS: Well, adequate being a relative
19 term, and the geographical area of the Province, and the
20 population being so thinly dispersed in many areas, even
21 considering the relative term, I would say no, but on the
22 other hand how far can you go with adequate medical
23 service where you have people at such a very, very thinly
24 dispersed over many areas in the Province. By almost
25 any understanding of the term adequate, I would say that
26 we could hardly ever expect to get adequate service in
27 the thinly populated areas. If you consider adequate
28 service as the service you would get in the metropolitan
29 area, if we use that for the moment as a standard, because
30 we have got a very, very large geographical area with
thinly spaced population.

31 COMMISSIONER BALTZAN: I appreciate that
32 sir. Except for those areas, this is very true. Speaking



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3 generally, do you believe people are suffering more from
4 the lack of financial resources than the availability
5 of the necessary health services?

6 MR. EVANS: That is true in the, what you
7 might call the disaster areas, or distress areas, which
8 have been previously set up in years gone by as areas of
9 very low economic yield, then their major distress would
10 come from their low income, or low production, and con-
11 sequently low income, rather than medical care in itself.
12 If you want to place the two on a comparative basis
13 sir. Does that answer your question?

14 COMMISSIONER BALTZAN: Yes, thank you.

15 MR. ZUNIC: I might suggest if we can
16 raise the economy of any given area, I think the other
17 will come to some degree.

18 COMMISSIONER BALTZAN: I didn't get that
19 sir.

20 MR. ZUNIC: If we raise the ability of
21 individuals in these defined depressed areas economically
22 through industry or some other endeavour which will allow
23 them to earn a better income, this will be offset and the
24 opportunity to support themselves will be increased.

25 COMMISSIONER FIRESTONE: If I understand
26 you correctly sir, the point that you are making is that
27 if everybody's income could be raised to such a level
28 that he could pay for his medical services himself, we
29 wouldn't need a State-supported plan, but until such a
30 millenium is reached we need the plan in the meantime.
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4 not providing, looking after the Province and encouraging
5 development. This is a new Province and a new nation
6 frankly, and we are going to have remote areas for many
7 years, and if we are going to establish remote areas
8 whatever standard is established as a standard, we are
9 going to have to assist those areas.

10 COMMISSIONER McCUTCHEON: But in all your
11 travels around the Province you have not run into a case
12 of a person who, having been where medical service was
13 available, failed to obtain medical care?

14 MR. ZUNIC: To our knowledge, yes.

15 MR. EVANS: I wouldn't like that to be
16 misconstrued, because in our travels in these areas we
17 have been meeting with people who are predominantly from
18 the rural villages and towns, and we do have some
19 representation from farmers, but we wouldn't necessarily
20 have an opportunity of getting reports of isolated cases.
21 They could be isolated cases of that nature.

22 COMMISSIONER McCUTCHEON: All I said was
23 that you haven't heard about them?

24 MR. EVANS: No, that is true.

25 COMMISSIONER FIRESTONE: But it is also
26 true that a number of people in those areas may not have
27 sought medical care, because they couldn't afford it,
28 and the fact that they couldn't pay for it would be an
29 impediment to people to seek medical care from your
30 knowledge of rural areas?

MR. EVANS: Oh, yes, that is true. There
are a large number of Indian people of course through
Manitoba, who are definitely in that class of people who



not providing, looking after the Province and encouraging development. This is a new Province and a new nation frankly, and we are going to have remote areas for many years, and it will take a long time to get them up to the standard of the rest of the Province. We are going to have to assist these areas.

COMMISSIONER MCCUTCHON: But in all your travels around the Province you have not run into a case of a person who, having been where medical service was available, failed to obtain medical care?

MR. EVANS: To our knowledge, yes.
MR. EVANS: I wouldn't like that to be misconstrued, because in our travels in these areas we have been meeting with people who are predominantly from the rural villages and towns, and we do have some representation from farmers, but we wouldn't necessarily have an opportunity of getting reports of isolated cases. They could be isolated cases of that nature.
COMMISSIONER MCCUTCHON: All right, was

that you haven't heard about them?
MR. EVANS: No, that is true.
COMMISSIONER FINESTON: But it is also true that a number of people in these areas may not have sought medical care, because they couldn't afford it, and the fact that they couldn't pay for it would be an impediment to people to seek medical care from your knowledge of rural areas?

MR. EVANS: Oh, yes, that is true. There are a large number of Indian people of course through Manitoba, who are definitely in that class of people who



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3 do not tend to seek medical care on that basis.

4 COMMISSIONER McCUTCHEON: A number of what
5 kind of people?

6 MR. EVANS: Indians, and other people.

7 COMMISSIONER McCUTCHEON: Aren't they
8 given special consideration by the Federal Government.
9 That isn't really the problem we are talking about this
10 morning.

11 MR. EVANS: No, we can leave the Indian
12 people outside.

13 COMMISSIONER FIRESTONE: But leaving the
14 Indian population aside, would you say that there are
15 other Manitobans in that group?

16 MR. EVANS: Yes, there are, and must be
17 a number of other people who are in that class.

18 COMMISSIONER McCUTCHEON: But I take it
19 by the way you qualified your answer to the question as
20 to people who need help, you don't think there are
21 300,000 people in that class?

22 MR. EVANS: I doubt whether there are
23 300,000 people in that class who couldn't pay moderate
24 premiums.

25 COMMISSIONER VAN WART: If people in this
26 area become sick, they get medical care, but there may
27 be cases where there is a little delay in getting that
28 medical care, would that cover it?
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COMMISSIONER MOUNTBATHEN: But I take it

by the way you qualified your answer to the question as
to people who need help, you don't think there are

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MR. EVANS: I doubt whether there are

800,000 people in that class who couldn't pay medical

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COMMISSIONER VAN WART: If people in this

area become sick, they get medical care, but there may
be cases where there is a little delay in getting that
medical care, would that cover it?



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4 MR. EVANS: Yes, that would be so in many
5 cases, especially in the isolated cases where the
6 geographical area is such you have a great distance from
7 the nearest hospital or the nearest doctors.

8 COMMISSIONER VAN WART: The problem is,
9 how are you going to rectify this delay in getting
10 adequate medical care?

11 MR. EVANS: There is a problem there, but
12 immediately it raises another problem, in that how can
13 that be so --there is a limit to the number of doctors
14 and hospitals you can have to a square area geographically,
15 and the number you can have similarly to a thousand
16 population spread over several hundred square miles.
17 There has definitely got to be a limitation.

18 COMMISSIONER VAN WART: But the children
19 all get to school, though?

20 MR. EVANS: Yes, that is true.

21 COMMISSIONER FIRESTONE: Would you support
22 an air ambulance service or a flying doctor service for
23 the outlying northern areas of Manitoba?

24 MR. EVANS: Anything that will take care
25 of people who are in distress and who are unable to
26 provide for themselves, yes, we would support.

27 MR. ZUNIC: This is done to some degree
28 with the Department of Northern Affairs. This is done
29 to some degree in the northern areas of Canada looking
30 after the Indians, and the Department of Northern Affairs
runs such a service, particularly in the areas of
dentistry.

COMMISSIONER BALTZAN: It was said that

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4 people in low income brackets seem to require more health
5 care than people in the higher income brackets. Would
6 you say the cause there is strictly because, or perhaps
7 mostly because they lack so many of the necessities of
8 life?

9 MR. EVANS: Such as, a fully balanced diet,
10 and poor dental care, for instance, which, of course, as
11 we know, contributes towards disease and illness. Your
12 basis for your higher incidence of sickness among the
13 people of low productive -- I don't think there is any
14 question about that contributing more to disease and
15 sickness: Yes, I would go along with your contention.

16 THE CHAIRMAN: Thank you very much,
17 gentlemen, for your assistance. We are grateful to you
18 for coming here this morning with the views you have
19 expressed.

20 MR. EVANS: Thank you, sir. We trust
21 we have been of some assistance to you.

22 THE CHAIRMAN: You certainly have been.
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THE CHAIRMAN: You certainly have been.



THE CHAIRMAN: We will now hear from the
Federation of Senior Citizens Clubs of Manitoba.

---EXHIBIT NO. 77A: Submission by Mr. A.C.
Froude.

---EXHIBIT NO. 77B: Submission by Mr. T.
Marshall.

SUBMISSION OF

SENIOR CITIZENS FEDERATION OF MANITOBA

APPEARANCES:

MR. A. C. FROUDE - Past President

MR. T. MARSHALL - President

MR. FROUDE: Mr. Chairman, and members
of the Royal Commission I respectfully submit the
following brief on behalf of the Senior Citizens Federa-
tion of Manitoba, in the hope that we can help you in the
task that is before you to arrive at the best possible
solution for a Canadian Health Services Plan.

We feel that the problem of Health Services
is a National one, and only by a central body can the
greatest efficiency and economy be obtained.

We further suggest that the Government
should as soon as possible create such a body, who will
set up in each province the necessary services to carry
out the overall plan. The plan should assure that all
Canadian be given full coverage for all health needs,
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Submission by Mr. A.C.

---EXHIBIT NO. 77A:

Submission by Mr. T. Marshall.

---EXHIBIT NO. 77B:

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3 of sickness.

4 Voluntary medical plans cost have become
5 prohibitive to most people over 65. This can be seen
6 in the present MMS rates where a single person pays
7 \$51.00 per year and a married couple \$142.00 per year.

8 THE CHAIRMAN: Is that over 65?

9 MR. FROUDE: That is at any age, sir,
10 regardless of what you may have coming in. This would
11 seem to prove that a couple can not live cheaper than one.

12 I might add here this has been in our
13 papers lately about the older people -- the fact that two
14 can live cheaper than one: That is how I got my wife;
15 I told her that story years ago.

16 Due to the over-lapping in a great many
17 cases administration costs under various voluntary plans
18 have proven very costly. This is another reason why an
19 efficient central agency could establish a greater economy
20 for the benefit of all concerned.

21 It would appear that in the last 25 years,
22 hospital costs have increased beyond expectations. Proof
23 of this can be shown in the following figures taken from
24 hospital receipts of 1940 and 1959. Also figures taken
25 from MHSP pamphlet for 1960. In 1940 hospital care
26 under Blue Cross was .75¢ per single person and \$1.00 per
27 family. Semi-private ward care was \$4.70 per day. 1959
28 MHSP costs were \$2.05 per person, standard ward care was
29 \$12.00 per day. Previous to being taken over by MHSP the
30 costs were much higher. In 1960 figures taken from MHSP
pamphlet shows costs were \$3.00 single and \$6.00 per
family per month. It must be noted that as of January
1st, 1962 these rates have been reduced by the Government



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3 to \$2.00 single and \$4.00 per family with the same ward
4 service. Another proof that a central body can control
5 costs.

6 Surely a plan could be formulated whereby
7 people over 65 who do not have a taxable income be exempt
8 from payment for these services. By setting the Income
9 Tax as a basis it would eliminate the needs for costly
10 Means Test Investigations.

11 It becomes necessary that only a full
12 Government controlled ~~plan~~ can become effective. Other
13 countries have proved this for in spite of defects and
14 so-called taking away of freedoms no Government regardless
15 of political beliefs have dared to take away the various
16 National Health plans in the different countries.

17 Surely with our high standard of living
18 it should not be necessary for old people to go hither
19 and yon to get much needed help. Many are not physically
20 able to do this.

21 There is possibly a better plan than the
22 one previously mentioned, and one if proven successful
23 could lead to an improvement in our Canadian economy. This
24 plan would require that all persons over 65 be subsidized
25 up to, at least, the income tax level, this would enable
26 the recipient to pay their share of the Health Plan costs.
27 At first glance this might be considered impossible, but
28 second thoughts will show that there are tremendous
29 possibilities in this idea. This would eliminate 20,000
30 people who are under Medi-Care plan, who would no longer
be in need of that service. There would be a considerable
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4 Various other welfare costs would automa-
5 tically vanish. Further, the elderly people receiving
6 the subsidy could spend more freely, pay for better
7 living quarters, and live their remaining years in peace
8 and dignity. It must not be overlooked that these dollars
9 would be kept in constant circulation.

10 Finally we feel that all research pro-
11 grams such as cancer, heart, mental, psychiatric, etc.
12 should be the full responsibility of the Canadian Health
13 Services Plan. Chiropractors and Osteopaths and Dentists
14 who are recognized should also come under this scheme,
15 because larger increasing numbers are seeking relief from
16 them with excellent results. Where health is concerned
17 the door should be left open to all.

18 THE CHAIRMAN: Thank you, Mr. Froude.
19 Perhaps we will hear from Mr. Marshall, and then we may
20 direct the questions to either one of you.

21 MR. MARSHALL: Mr. Chairman and members of
22 the Royal Commission: We thank you for your courtesy in
23 listening to us, the oft forgotten section of Canada's
24 populace.

25 I might say on top of this, that while
26 we are oft forgotten, the Governor-General yesterday didn't
27 forget to tell us they have considered giving us a little
28 increased pension.

29 We regret that we are not passing briefs
30 around to members of the audience here, but the great
percentage of our senior citizens find it difficult to
meet daily expenses, so the financial position of our
organization has to be carefully scanned.

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4 Our affiliated clubs are unanimously agreed
5 that a National Health Service is most desirable, and
6 the sooner it can be brought into operation the better,
7 for the good and welfare of all our people in this vast
8 country.

9 Many of our senior citizens however ask
10 how much such a scheme may cost the individual.

11 In some of the medical plans single people
12 are charged fixed premiums, married people are called to
13 pay a family premium three or more times that of a single
14 person. Note how this affects the helpless old pair with
15 Old Age Pensions of \$110.00 or little more per month.

16 Most of these elderly people cannot get
17 into group plans whereby reduced premiums are often
18 granted.

19 We, therefore, believe that this Health
20 of the nation scheme should be financed along the same
21 lines as that of other National services e.g. postal,
22 National communications, defence, services, etc. or
23 charge a small premium from all adults and raise the
24 remainder of costs for the service by a slight increase
25 on the income tax, or by the often criticized sales tax,
26 thus reducing the amount to be paid to those with small
27 incomes, notably aged people who cannot work and in many
28 cases can't get work even if physically fit.

29 Another means of raising money, much of it,
30 aye perhaps most of it might be raised outside of Canada,
of course it would mean a change in the Criminal Code, but
necessity is the mother of many things, Sweepstakes,
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4 We would draw attention to the fact that
5 our Provincial Government recently lowered the premiums
6 on hospitalization by 33-1/3 per cent. and had income
7 tax increased to meet the required revenue, thus the
8 elderly people got the reduction while the high income
9 group paid the higher tax.

10 However, all younger people paying a little
11 extra now to help the aged do it with the knowledge that
12 they will become Old Age Pensioners some day or that they
13 at least hope to be.

14 THE CHAIRMAN: Thank you, Mr. Marshall.

15 COMMISSIONER FIRESTONE: Mr. Chairman,
16 if I may address my questions to both gentlemen and leave
17 it to their good judgment as to who wishes to answer:
18 My first question is, sir, are there many elderly people,
19 senior citizens covered under the Medicare plan in the
20 Province of Manitoba?

21 MR. FROUDE: Yes, there are quite a number,
22 but I would not venture to say what percentage. Many of
23 our elderly citizens, retired from the railway and govern-
24 ment and civic services carry medical plans, but I would
25 say the big majority don't carry medical plans at the
26 present time.

27 COMMISSIONER FIRESTONE: You are referring
28 to people covered by medical plans: Could I narrow it
29 down to the Medicare programme of the Province of Manitoba?
30 Are there many senior citizens covered by the Medicare
programme of the Province of Manitoba?

MR. FROUDE: If I may answer that question
-- in fact, I have answered it here: This figure, I
think, was given last Monday: 20,000 people who are under



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3 the Medicare plan. I would like to point this out,
4 gentlemen, that here is where one of the weaknesses in
5 these systems comes in. Mr. Marshall made reference to
6 the fact that there is liable to be a slight increase in
7 the pension. Now, 20,000 people, if they get that slight
8 increase, are going to be put above the amount required
9 for them to get Medicare.

10 THE CHAIRMAN: Do you suggest that the
11 whole of the 20,000, which was the figure given by
12 Premier Roblin, are in the over 65 age class, or does
13 that cover the whole group?

14 MR. FROUDE: I would not think so. There
15 are others below that. It may be considered by some that
16 we are talking for the old people: Well, that is who
17 we represent, but my own idea is that eventually great
18 thought will have to be given to the young people as well
19 as the old, and also to the blind and to other organiza-
20 tions that need this.

21 COMMISSIONER FIRESTONE: If I understand
22 you, you are making a case for a universal scheme that
23 is applicable to everybody irrespective of age?

24 MR. FROUDE: Yes, I do.

25 COMMISSIONER FIRESTONE: If I may pursue
26 the question of the position of the senior citizens for
27 the moment: You are knowledgeable of the situation, and
28 the Commission is trying to learn how this works in
29 practice in Manitoba. What income level must a senior
30 citizen have to be eligible under the Medicare programme
in Manitoba?

MR. FROUDE: I tried to get those figures,

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TORONTO, ONTARIO

Froude

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4 and it is a rather difficult thing to get hold of, but I
5 did phone up the other day and found out that I had the
6 wrong department. I had the department that takes care
7 of those from 60 to 70 -- until they receive a pension.
8 I found certain figures there, and then, when I finally
9 found what I was doing -- because the young lady informed
10 me I was on the wrong wire -- and that I needed those who
11 were on Medicare, and she put me on to that department.
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and it is a rather difficult thing to get hold of, but I
 did phone up the other day and found out that I had the
 wrong department. I had the department that takes care
 of those from 50 to 70 -- until they receive a pension.
 I found certain figures there, and then, when I finally
 found what I was doing -- because the young lady informed
 me I was on the wrong wire -- and that I needed those who
 were on Medicare, and she put me on to that department.



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4 I found a great difference between the man between 65 and
5 70 and all the others on pension. And now, the pension
6 from the figures I got over the phone was that a person
7 \$660.00 or \$55.00 a month could have \$500.00 a year of
8 assets of some form or other but could have no more.

9 THE CHAIRMAN: Assets or income?

10 MR. FROUDE: Assets, that is, they could
11 have \$500.00 in the bank. Their income would be \$660.00
12 but their assets could be any kind of bonds and a bank
13 account. If somebody should come along and take pity on
14 them and offer to pay their rent then that becomes part
15 of their income and automatically takes them off the
16 Medicare plan.

17 COMMISSIONER FIRESTONE: In other words,
18 what you are saying to us is that anyone who receives
19 more than \$55.00 a month, say \$60.00, \$70.00 a month is
20 not eligible?

21 MR. FROUDE: They are out automatically.

22 MR. MARSHALL: I did discuss this with
23 the Premier and the Minister of Health. I had looked
24 through the health plan or the Medicare plan in Manitoba
25 and I noticed that the difference in Manitoba from
26 Alberta, for instance, was that they did not mention the
27 amount agreed upon between the Dominion and Provincial
28 Governments for supplementary pensions. I suppose you
29 all know of these things but that amount is \$135.00 per
30 month per married couple or \$1620.00 a year. In some of
the provinces they immediately get a supplementary pension
if they do not have an income in excess of \$1,620.00 and
they get Medicare on top of that. I asked the Premier, or

I found a great difference between the man between 65 and 70 and all the others on pension. And now, the pension from the figures I got over the phone was that a person 65 or 66 or 67 or 68 or 69 or 70 could have \$500.00 a year of assets of some form or other but could have no more.

THE CHAIRMAN: Assets or income?

MR. PROUD: Assets, that is, they could have \$500.00 in the bank. Their income would be \$500.00 but their assets could be any kind of bonds and a bank account. If somebody should come along and take pity on them and offer to pay their rent then that becomes part of their income and automatically takes them off the Medicare plan.

COMMISSIONER FREDERICK: In other words,

what you are saying to us is that anyone who receives more than \$50.00 a month, say \$60.00, \$70.00 a month is not eligible?

MR. PROUD: They are not automatically.

MR. MARSHALL: I did discuss this with

the Premier and the Minister of Health. I had looked through the health plan or the Medicare plan in Manitoba and I noticed that the difference in Manitoba from Alberta, for instance, was that they did not mention the amount agreed upon between the Dominion and Provincial Governments for supplementary pensions. I suppose you all know of these things but that amount is \$135.00 per month per married couple or \$160.00 a year. In some of the provinces they immediately get a supplementary pension if they do not have an income in excess of \$1,600.00 and they get Medicare on top of that. I asked the Premier, on



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4 rather I remarked to the Premier that this plan looked
5 like a beggar's plan to me because they did not express
6 any particular amounts of income in the health plan and
7 people sometimes were scared to go and ask for any
8 Medicare. The Health Minister told me they had intentionally
9 left the amounts out because some people might have more
10 than \$1,620.00 a year and get assistance while others
11 with less might not get assistance depending upon the
12 requirements for health services and so forth that they
13 perhaps had to lay out money on. I said, "In other words,
14 gentlemen, the person who can come along and put up the
15 best case to you has a better chance of getting assistance
16 because there are some people who are afraid to come
17 because they might be turned down and they are not very
18 glib in building up the amounts of expenses and so forth
19 that they are charged". The \$1,620.00 a year is roundly
20 the figure under which people could come under Medicare.

21 COMMISSIONER FIRESTONE: A single person
22 receiving an income of more than \$55.00 a month is not
23 eligible under the Medicare plan as things stand at the
24 moment?

25 MR. MARSHALL: It depends on what he is
26 paying for rent according to the Welfare organizations
27 here in the city and what other definite out of pocket
28 expenses he has they allow a certain amount, I believe it
29 is something like \$42.00 a month for food for couples
30 and that would amount to \$21.00 a month for a single
person. They add all the definite expenses a person has
and they give him enough to live on even if it comes to
considerably more than \$1,620.00 a year.



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4 COMMISSIONER FIRESTONE: In other words,
5 what you are saying is that under certain circumstances
6 people will be eligible to receive Medicare even though
7 their income is, a single person, is more than \$55.00
8 a month?

9 MR. MARSHALL: Definitely.

10 COMMISSIONER FIRESTONE: Would you also
11 be saying this would be true if the person received more
12 than \$75.00 a month?

13 MR. MARSHALL: In some cases.

14 COMMISSIONER FIRESTONE: Would you say this
15 would be true of persons receiving more than \$85.00 a
16 month?

17 MR. MARSHALL: I do not think it would
18 apply to persons receiving \$85.00.

19 COMMISSIONER FIRESTONE: I would assume
20 that the group that receive \$85.00 and more, assuming people
21 between \$55.00 and \$85.00 with the good graces of the
22 Medicare programme could become eligible. Let us talk
23 about groups that are definitely not eligible. Would
24 you say there are many citizens in the Province of Manitoba
25 that receive \$85.00 per month or more that are not covered
26 either by Medicare or by other medical insurance plans?

27 MR. MARSHALL: I believe there is quite
28 a percentage receiving over \$85.00 a month that would not
29 look for Medicare.

30 COMMISSIONER FIRESTONE: You suggested that
people in that bracket would not be eligible even if they
wanted to be on a single person basis?

MR. MARSHALL: I would not say that at all.



COMMISSIONER FINANCE: In other words,

people will be eligible to receive Medicare even though their income is, a single person, is more than \$35.00

a month?

COMMISSIONER FINANCE: Would you also

be saying this would be true if the person received more

than \$35.00 a month?

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COMMISSIONER FINANCE: Would you say this

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MR. MARSHALL: I do not think it would

apply to persons receiving \$35.00.

COMMISSIONER FINANCE: I would assume

that the group that receive \$35.00 and more, assuming people

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a percentage receiving over \$35.00 a month that would not

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MR. MARSHALL: I would not say that at all.



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4 I would say, if they are not in the income tax group I
5 would very strongly suggest that they get Medicare.

6 COMMISSIONER FIRESTONE: You suggest they
7 should get it but we should distinguish between what people
8 should get and what they do get.

9 MR. MARSHALL: You mean what they are
10 getting at the present time?

11 COMMISSIONER FIRESTONE: Yes, sir.

12 MR. MARSHALL: I have no idea what per-
13 centage of the people get over \$85.00 a month but I do not
14 think any of them would be getting Medicare at the govern-
15 ment's expense.

16 COMMISSIONER FIRESTONE: That is what I am
17 getting at. Talking about the group that are not getting
18 Medicare, the group that are not covered by a medical
19 insurance plan and they are receiving, according to what
20 you suggested, it may be \$85.00 or more. I am not asking
21 you how many there are. We are assuming there is a
22 number. All we are interested in is finding out what do
23 these people do when they need medical attention. He has
24 \$85.00 and is not covered by the Plan and there are many
25 people in this group; if a person gets sick what does
26 he do?

27 MR. FROUDE: If I might try and answer
28 that question. A person with \$85.00 or less may get some
29 advice to go to one of our many charitable, what we call
30 charitable organizations. Now, when they get there they
are shifted from one office to another; "this particular
thing does not come under this office, go down to so and
so". I will say this, the government officials in all of

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COMMISSIONER FLEMING: Yes, sir.

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centage of the people get over \$25.00 a month but I do not think any of them would be getting Medicare at the government's expense.

COMMISSIONER FLEMING: That is what I am

getting at. Talking about the group that are not getting

Medicare, the group that are not covered by a medical insurance plan and they are neglected, according to what you suggested, it may be \$1.00 or more. I am not saying

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that question. A person with \$25.00 or less may get some advice to go to one of our many charitable, what we call charitable organizations, now, when they get there they are shifted from one office to another; "this particular thing does not come under this office, go down to so and so". I will say this, the government officials in all of



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4 these cases give these people the best service they have
5 got, in fact, I have been told how these different people
6 feel themselves when they get home at night and realize
7 the run-arounds that these people do get. But, when they
8 come at \$85.00 a month, and I will say less than that,
9 as I said before, \$660.00 was the sum quoted to me that
10 he could have for an income. If you should get your
11 \$30.00 rent paid that is included in your income and
12 automatically puts you out of Medicare.

13 COMMISSIONER FIRESTONE: This is a very
14 helpful description of the problem that people in the
15 group face. Could you just explain to us what does a
16 person in that position do? He is sick, he needs medical
17 attention and you said he goes to a charitable organiza-
18 tion and says "Please, I am sick, I need help, what do
19 I do?". Can you describe the process of what he does?

20 MR. FROUDE: He could do one of two things,
21 he could either go home and lay down on a bed and possibly
22 die or they could go to the City Welfare. Again, great
23 consideration is given to if they are outside of certain
24 privileges then they get no help so what do they do? There
25 is only one thing to do and that is to go home and either
26 lay down and sleep it off or lay down and sleep it off
27 for good, to be very frank about it. That is the one
28 reason, that is the reason why a better comprehensive
29 plan for Canada is needed. In this country we should no
30 longer have the necessity for charity cases. If I might
make a remark, gentlemen, three years ago I was in Great
Britain and I made it my business to get in touch with
some welfare groups over there. The first lady I went to



these cases give these people the best service they have
 got, in fact, I have been told how these different people
 feel themselves when they get home at night and realize
 the run-arounds that these people do get. But, when they
 come at \$25.00 a month, and I will say that that
 as I said before, \$250.00 was the sum quoted to me that
 he could have for an income. If you should get your
 \$30.00 rent paid that is included in your income and
 automatically puts you out of Medicare.

COMMISSIONER (Rising): This is a very
 helpful description of the problem that people in the
 group face. Could you just explain to us what loss a
 person in that position does. He is sick, he needs medical
 attention and you said he goes to a charitable organiza-
 tion and says "Please, I am sick, I need help, what do
 I do?". Can you describe the process of what he does?

MR. PROUD: He could do one of two things.
 He could either go home and lay down and sleep and possibly
 die or they could go to the City of Toronto. Again, great
 consideration is given to all they are capable of doing.
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 is only one thing to do and that is to go home and either
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4 was Dame Kelly of Portsmouth who was mayoress at one time
5 of Portsmouth and she was the head of Welfare. She was
6 the one that informed me, she said, "Mr. Froude, we do
7 not give charity, we have no charity. If people come to
8 us for charity we tell them that we have no charity to
9 give; if people come to us or if we find out that people
10 do not want to accept charity we tell both parties that
11 you get no charity, you get welfare which you are entitled
12 to."

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14 Charity to people over there is counted
15 as bad. There is no charity, it is welfare and they
16 definitely state it is something that belongs to you.

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18 COMMISSIONER FIRESTONE: If I may get a
19 little bit of help from you just to explain what does
20 happen if a person goes to the welfare agency and says:
21 "I am terribly sick, I have a high temperature, my chest
22 is hurting me", and the person goes to the welfare agency,
23 what happens then?

24
25 MR. FROUDE: Well now, there is a possibility
26 there -- it happened to me just some five weeks ago. The
27 only thing is, if they know, and most of our people do not
28 know, if they are in that state, if they are an emergency
29 case they go and get somebody to take them to the hospital
30 and go into emergency and they are taken care of. Then
somebody afterwards has to pay the bill, they cannot
and somebody has to. That is as far as I can go.

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32 COMMISSIONER FIRESTONE: As far as emergency
33 is concerned but when somebody is sick without requiring
34 emergency treatment what would this welfare agency say
35 to this person? A person comes in and says "I am not
36 feeling well, I need some medical attention". What does

was Dame Kelly of Portsmouth who was mayoress at one time of Portsmouth and she was the head of welfare. She was the one that informed me, she said, "Mr. Trowde, we do not give charity, we have no charity. If people come to us for charity we tell them that we have no charity to give; if people come to us or if we find out that people do not want to accept charity we tell both parties that you get no charity, you get welfare which you are entitled

Charity to people over there is counted as bad. There is no charity, it is welfare and they definitely state it is something that belongs to you. COMMISSIONER FLETCHER: If I may get a little bit of help from you just to explain what does happen if a person goes to the welfare agency and says, "I am terribly sick, I have a high temperature, my chest is hurting me", and the person goes to the welfare agency what happens then?

MR. TROWDE: Well now, there is a possibility there -- it happened to me just some five weeks ago, the only thing is, if they know, and most of our people do not know, if they are in that state, if they are an emergency case they go and get somebody to take them to the hospital and go into emergency and they are taken care of. Then somebody afterwards has to pay the bill, they cannot and somebody has to, that is as far as I can go.

COMMISSIONER FLETCHER: As far as emergency is concerned but when somebody is sick without realizing to this person? A person comes in and says "I am not feeling well, I need some medical attention". What does



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4 this agency do to the person?

5 MR. MARSHALL: Mr. Chairman, I had a case
6 next door to me just a few weeks ago, a poor old couple
7 with a blind son. They had just around the figure we
8 are discussing, \$85.00 each a month. They went to the
9 Welfare and Welfare sent a man out to see them and dis-
10 cuss with them. He saw how they moved around and he was
11 touched, I am quite certain, and he checked up with them
12 all the expenses they had. The old lady could not do many
13 things, she just slipped back and forth across the floor.
14 The husband came into my house after I had advised him to
15 see Welfare and thanked me for having advised them to
16 go because they had promised to give he and his wife
17 free medicine. That was all he was asking for. The same
18 old chap came into my house last night and I just want to
19 tell you this because it is not every day you see it; he
20 said, "You know, if we just get \$10.00 a month on our
21 pension I will tell the Welfare I don't want their medi-
22 cine anymore, I won't ask them to send it to me."

23 COMMISSIONER BALTZAN: What happens when
24 these people are too sick to walk around to these agencies,
25 how do they get help?

26 MR. MARSHALL: I have known a number of
27 cases that have walked around and finally the Welfare does
28 take care of them to some extent,

29 COMMISSIONER BALTZAN: What Welfare is
30 that?

MR. MARSHALL: Provincial Welfare Depart-
ment.

MR. FROUDE: I might say this, they could
do it if they know about it but the person of which you

this agency do to the person?

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with a blind son. They had just around the figure we

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MR. MARSHALL: I don't know Welfare doesn't

ment.

MR. FROST: I might say this, they could

do it if they know about it but the person of which you



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4 are speaking, I would say that 99% of them would not know
5 who to call. In the case in which you say you would be
6 too sick to call and who are they going to get to call,
7 they will try and get help of a neighbour.

8 COMMISSIONER FIRESTONE: Could they not
9 call a doctor?

10 MR. FROUDE: Call a doctor?

11 COMMISSIONER FIRESTONE: Yes, that is the
12 normal thing to do when you are sick?

13 MR. FROUDE: Well, call a doctor and what
14 do you get? "Come down to the office".

15 COMMISSIONER FIRESTONE: If the man says
16 "I am too sick to come to the office", what happens then?

17 MR. FROUDE: Well, if it is night it is
18 a possibility you wait until morning. But, again, now
19 we are not young people, we are old people and in our
20 day the doctors came nearly every time. I never once
21 failed to have a doctor. I am here to say that I have
22 a great regard for doctors, I have a great regard for
23 nurses and I have a great regard for everybody in the
24 hospital when you go there to the hospital. The old
25 generation were called tough, the new generation have to
26 face it that you might happen to get a doctor who would
27 come out to them. However, their hope of getting a
28 doctor out these days is very remote. I believe there
29 was a matter talked of about a deterrent. There has always
30 been a deterrent because it used to cost \$2.00 to go to
the office and \$3.00 for a visit; it is now \$3.00 to go
to the office and \$5.00 to get a visit if you can get the
visit. Is that \$2.00 not enough deterrent? How those

are speaking, I would say that 80% of them would not know who to call. In the case in which you would be too sick to call and who are they going to get to call, they will try and get help of a neighbour.

COMMISSIONER FLEMING: Could they not

call a doctor?

MR. PROCTOR: Well, I think that is the

COMMISSIONER FLEMING: Yes, that is the

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3 people are going to get a doctor to come out I do not
4 know. That is just one of those things. As I say, I was
5 in that kind of circumstance but it was the doctor's
6 advice that sent me where I went but how many are to know
7 that? You see, these questions you are asking us to
8 answer are not in our power, we have not got to say what
9 any doctor might do.

10 COMMISSIONER FIRESTONE: We are just trying
11 to enquire from your experience. There are many elderly
12 citizens with low incomes who are not covered either by
13 Medicare or by a medical insurance plan who have difficulty
14 in obtaining medical services and to pay for it. This
15 is what we are trying to establish, whether from your
16 experience this is the situation in Manitoba or it is not,
17 we ask the benefit of your knowledge.

18 MR. FROUDE: Again I can only quote a
19 figure that the Premier brought up the other day and which
20 also appeared in the paper last night although I noticed
21 in the paper last night it increased by 50,000. Our
22 Premier mentioned there are 300,000 people in Manitoba
23 without any medical care plan of any kind. He is in a
24 much better position to know this than I. Now, why are
25 they in that position? I would say that 90% of them
26 definitely cannot afford the necessary requirements to
27 take a chance to pay for any kind of care.

28 COMMISSIONER FIRESTONE: If I understand
29 you correctly you feel there should be a universal medical
30 care plan in existence in Manitoba that would look after
the medical care requirements of people that cannot afford
to pay?



people are going to get a doctor to come out I do not know. That is just one of those things. As I say, I was in that kind of circumstance but it was the doctor's advice that sent me where I went but how many are to know that? You see, these questions you are asking us to answer are not in our power, we have not got to say what any doctor might do.

COMMISSIONER FINESTON: We are just trying to enquire from your experience. There are many elderly citizens with low incomes who are not covered either by Medicare or by a medical insurance plan who have difficulty in obtaining medical services and to pay for it. This is what we are trying to establish, whether from your experience this is the situation in Manitoba or it is not we ask the benefit of your knowledge.

MR. PRODD: Again I can only quote a figure that the Premier brought up the other day and which also appeared in the paper last night although I noticed in the paper last night it increased by \$6,000, 000. Premier mentioned there are 300,000 people in Manitoba without any medical care plan of any kind. He is in a much better position to know this than I. Now, why are they in that position? I would say that 95% of them definitely cannot afford the necessary requirements to take a chance to pay for any kind of care.

COMMISSIONER FINESTON: If I understand you correctly you feel there should be a universal medical care plan in existence in Manitoba that would look after the medical care requirements of people that cannot afford to pay?



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3 MR. MARSHALL: Definitely.

4 COMMISSIONER FIRESTONE: And this could be
5 a comprehensive plan and available to all?

6 MR. FROUDE: Absolutely to all.

7 COMMISSIONER FIRESTONE: And this would
8 be a matter of right and not a matter of charity?

9 MR. FROUDE: Definitely.

10 COMMISSIONER FIRESTONE: Thank you, you
11 have been very helpful.

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COMMISSIONER FIRSTONE: And this could be

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MR. PROCTOR: Absolutely to all.

COMMISSIONER FIRSTONE: And this would

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MR. PROCTOR: Definitely.

COMMISSIONER FIRSTONE: Thank you, you

have been very helpful.



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3 COMMISSIONER VAN WART: The Medicare plan
4 serves a useful purpose, does it not?

5 MR. FROUDE: Definitely it serves a useful
6 purpose, all of these plans serve a useful purpose.

7 COMMISSIONER VAN WART: It is a matter of
8 extending them?

9 MR. FROUDE: It is a matter of extending
10 them far enough to cover all, and that is why we have from
11 the beginning always advocated that those below the income
12 tax bracket should be taken care of. The reason stated,
13 I think, in here was that it stops, it avoids a lot of
14 costly investigation. Now, I believe that all of these
15 plans are all good. I think I heard you, Mr. Chairman,
16 state the other day, or somebody state, there was 38
17 different organizations, I forget the right number,
18 voluntary plan organizations, it may have been Mr. Fire-
19 stone, but there are a various number of organizations
20 in the country that are on a voluntary basis. Their costs,
21 they are repeating costs. They have got various depart-
22 ments where those departments could all be put into one.
23 Our Manitoba Medical Service is a case in point sir. The
24 idea of the Manitoba Medical Service was originally to
25 see that the doctors got, if not all of their collections,
26 the biggest part of them. And now the Government would
27 assure that, the government would definitely assure that
28 they did get, and maybe instead of 70%, get the 100% of
29 their collections. The central body would definitely
30 assure that.

31 Mr. Roblin by the way, sir, made a state-
32 ment the other day. He wished you had been six months
33

COMMISSIONER VAN WART: The Medicine plan

serves a useful purpose, does it not?

MR. KENNEDY: Definitely it serves a useful

purpose, all of these plans serve a useful purpose.

COMMISSIONER VAN WART: It is a matter of

extending them?

MR. KENNEDY: It is a matter of extending

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in the country that are on a voluntary basis. Their work

they are repeating over. They have had various depar-

ments where those departments could all be put into one.

Our Manitoba Medical Service is a case in point sir. The

idea of the Manitoba Medical Service was originally to

see that the doctors got, if not all of their collections

the biggest part of them. And now the Government would

assume that, the Government would definitely assume that

they did get, and make instead of 10%, get the 100% of

their collections. The general body would definitely

assume that.

MR. KENNEDY: By the way, sir, made a state-

ment the other day. He wished you had been six months



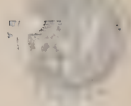
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3 later than this. I wish you had been twenty-five years
4 sooner. That is when we should have had a hospital
5 plan. We have been dragging our feet for years, on the
6 assumption that we are the highly standard nation, one of
7 the finest in the world. Now, it is very well for those
8 that are in that position, but there are hundreds of
9 thousands, there are over 900,000 old age pensioners in
10 this country, and again I cannot break down those figures,
11 but I guarantee, and I am going to make it as low as I
12 can, that 50% of those people cannot meet the needs of
voluntary plans for medical care.

13 I stated on this thing about the idea of
14 subsidizing people up to income tax level. That, gentlemen
15 of the Commission, that would not mean that I do not want
16 that central body to operate, regardless of that, but it
17 would mean that those people who are not able to achieve
18 some of the things they want would be --- the mental
19 effect, now we have the mental health plan comes under
20 this. What is the effect on those people who accept the
21 Medicare plan, who go to beg for assistance, the mental
22 effect on those people is a sickness that we are creating
that could be eliminated by such a plan as advocated.

23 THE CHAIRMAN: Thank you very much, Mr.
24 Froude and Mr. Marshall. You have been of help to us, and
25 we are grateful to you for having come.

26 MR. FROUDE: Thank you sir. That has been
27 our objective, and we hope we have accomplished it.

28 THE CHAIRMAN: Now this brings us to the
29 end of the list of those who had signified an intention
30 to make representations. Is there anyone else present who



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end of the list of those who had registered an intention
to make representations. Is there anyone else present who



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Froude 3873

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3
4 might wish to make a statement, or to put forward some
5 views for the consideration of the Commission?

6 Since there is no one who wishes to come
7 forward, has a desire to come forward, and since we
8 have concluded our hearing of those who did indicate
9 an intention to make submissions, the public hearings
10 insofar as the Province of Manitoba is concerned, are
11 now at an end, and again we want to thank all those who
12 participated in the hearings, who devoted so much time
13 and effort in the preparation of briefs and submissions,
14 and who have been so helpful to the Commission in the
15 past week.

16 Now we are going to have a closed meeting
17 of the Commission.

18 ---ADJOURNED.
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30



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ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

REGINA

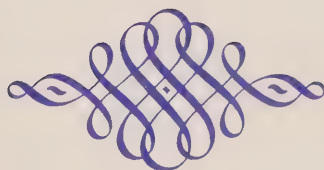
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VOLUME NUMBER:

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DATE:

JANUARY 22 1962



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V O L U M E 17

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Brief of the College of Physicians and Surgeons of Saskatchewan..	.4026
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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearing
held at Regina, Saskatchewan,
January 22nd, 1962.

COMMISSION MEMBERS:

CHIEF JUSTICE EMMETT H. HALL ----- Chairman

MISS ALICE GIRARD, R.N.

DR. DAVID M. BALTZAN

PROF. O. J. FIRESTONE

MR. M. WALLACE McCUTCHEON, Q.C.

DR. C. L. STRACHAN

DR. ARTHUR F. VAN WART

COMMISSION COUNSEL:

MR. R. N. HALL, Q.C.

MEDICAL CONSULTANT:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

SECRETARY:

MR. N. LAFRANCE

Proceedings of the hearing
held at Regina, Saskatchewan,
January 22nd, 1902.

COMMISSION MEMBERS:

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MISS ANNE GERRARD
DR. DAVID M. BATHMAN
PROF. O. J. FLEETON
MR. M. WALLACE MONTGOMERY, Q.C.
MR. ALTHUR T. VAN WART

COMMISSION COUNSEL:

MR. R. N. HALL, Q.C.

MEDICAL CONSULTANT:

DR. PIERRE JOLIN

DIRECTOR OF LABORATORY:

MR. N. LAMARCA



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

3875

Regina, Saskatchewan,
Monday,
January 22nd, 1962.

--- On commencing at 10.00 a.m.

THE CHAIRMAN: Ladies and gentlemen,

we will proceed to open the hearings of the Commission for the Province of Saskatchewan here in Regina. I have been telling my fellow Commissioners, particular last week in Winnipeg when it was so cold, that things would be much better in Saskatchewan, and I am glad, Mr. Minister, that you and your associates have arranged things so nicely, that it is much better this morning.

I see from our agenda that we have quite a full work load for the week, and that is a matter of much gratification because the more interest that is shown in the subject matter of this inquiry the better it will be in the long run, because it is only by getting the views of as many as have views to express that the Commission may be fully informed.

We are happy to welcome you here this morning, Mr. Minister, and to note that the Government of the Province of Saskatchewan has a submission, which we have had the opportunity of reading. There will be other submissions, of course. The public interest in the subject matter of health services and health care is very broad, and in every province where we have been it has been very pronounced, and we expect the same obtains here in Saskatchewan.

We would not be realistic if we did not say that we are aware that in this Province there exists

January 22nd, 1962.

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We would not be realistic if we did not

say that we are aware that in this Province there exist



1 a measure of disagreement between the Government on the
2 one hand and the College of Physicians and Surgeons on
3 the other. We have no intention of participating in that
4 discussion -- we have no intention of taking sides one
5 way or the other.

6 On the other hand the fact that the
7 subject of medical health services is a matter of some
8 discussion in Saskatchewan cannot be allowed to impede
9 or inhibit the work of the Commission. We must proceed
10 to do the job entrusted to us as set out in our terms of
11 reference in each Province that we visit taking things
12 as we find them.

13 It may be that certain questions may be
14 asked by myself or by one of my fellow Commissioners
15 which some may consider as indicating a view one way or
16 the other. Any speculating of that kind will be futile.
17 The questions which shall be put are put to elicit in-
18 formation and opinions and to ensure that we know exactly
19 what is meant by those making submissions and the full
20 implications of the submissions on a national as well as
21 on a provincial basis, and it is in that context that
22 we will proceed with the hearings here in Saskatchewan,
23 and it gives me pleasure to now call upon the Honourable
24 Mr. W. G. Davies, Minister of Public Health for
25 Saskatchewan, to present the submission on behalf of
26 the Government of the Province of Saskatchewan.

27
28
29
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It may be that certain questions may be asked by myself or by one of my fellow Commissioners which some may consider as indicating a view one way or the other. Any questioning of that kind will be futile. The questions which shall be put are put to elicit information and opinions and to ensure that we know exactly what is meant by those making submissions and the full implications of the submissions on a national as well as on a provincial basis, and it is in that context that we will proceed with the hearings here in Saskatchewan, and it gives me pleasure to now call upon the honourable Mr. W. G. Davies, Minister of Public Health for Saskatchewan, to present the submission on behalf of the Government of the Province of Saskatchewan.



SUBMISSION

of the

GOVERNMENT OF THE PROVINCE OF SASKATCHEWAN

APPEARANCES:

HON. W. G. DAVIES -- Minister of Public Health

DR. F. B. ROTH -- Deputy Minister of Public Health

DR. J. D. RAMSAY -- Director of Research and Statistics,

DR. M. S. ACKER -- Director of The Regional Health Services Branch

DR. V. L. MATTHEWS -- Director of the Medical and Hospital Services Branch

DR. F. S. LAWSON -- Director of the Psychiatric Services Branch

MR. C. P. FEADER -- Director of the Administrative Services Branch

MR. J. E. SPARKS -- Secretary of the Advisory Planning Committee on Medical Care.

--- EXHIBIT NO. 78: Brief of the Government of Saskatchewan

HON. MR. DAVIES: Mr. Chairman and members of the Commission, I wanted first of all to say that we too are pleased with the somewhat more temperate weather, and we are quite prepared to attribute this, sir, to the arrival of the Commission. We do certainly hope this will continue throughout your stay here.

I want also in beginning this morning, Mr. Chairman, this first submission to be given at the Saskatchewan hearings to voice to you a most sincere measure of welcome on behalf of the Government and the people of the Province. We do hope that the information and views we make known to you here will aid in the



1 formulation of the report that will ultimately be
2 completed. The people of Saskatchewan, as you are aware,
3 have displayed a keen and active interest in all matters
4 affecting health and they will follow these hearings
5 with a like interest. I do respectfully trust, Mr.
6 Chairman, that these hearings will prove to be valuable
7 in your final deliberations, and I again extend to the
8 Commission members a most cordial greeting from the
9 Government of Saskatchewan. Appearing with me today,
10 sir, are a number of my officials. They will be able
11 to supplement the information supplied in our brief.

12 My chief duty, Mr. Chairman, this morning
13 is to comment on the nature of the brief which has been
14 presented by the Government of Saskatchewan today and
15 which you, sir, have indicated has already been read.
16 Before doing so I would like to express the willingness
17 of the Government of this Province, and particularly my
18 own Department of Public Health, of the most sincere
19 co-operation in the way of providing the Commission with
20 any information that is needed and is available.

21 Our submission to this Royal Commission
22 is, as you will have recognized, a document which
23 attempts to set down our philosophy of the need for a
24 broadly based health service and to discuss some of the
25 ways in which health services might be developed to meet
26 the needs of Canadians. We have refrained from giving
27 details as to the available resources of facilities,
28 services and personnel in Saskatchewan, and we have
29 also refrained from providing estimates at this time as
30 to future needs. It is our belief that the catalogue



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2 completed. The people of Saskatchewan, as you are aware,
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25 ways in which health services might be developed to meet
26 the needs of Canadians. We are relieved from giving
27 details as to the available resources of facilities,
28 services and personnel in Saskatchewan, and we have
29 also refrained from providing estimates at this time as
30 to future needs. We do believe that the techniques



1 of resources and the estimation of future needs on a
2 national basis are only of value if data collected can
3 be measured in meaningful terms. For example, we can
4 tell you that there are 4,180 nurses on the registry of
5 the Saskatchewan Registered Nurses Association as of
6 December 31st, 1961. As such this figure, while it is
7 impressive for a province of this size, does not indicate
8 in any way how many of these nurses are now in or would
9 be available for employment or, on the other hand, how
10 many might be available in a major national emergency.
11 It has been our experience, Mr. Chairman, that the
12 measurement of both physical and personnel resources in
13 the health field requires careful definition prior to
14 the collection process being undertaken.

15 A considerable amount of activity in
16 this field has been going on in Saskatchewan in the past
17 few years, and particularly in the past two. As I have
18 indicated earlier, we will be most happy and indeed are
19 anxious to collect for the Commission and its research
20 officers all data they wish to obtain. These data are
21 in many instances available on punched cards, and these
22 can be sorted and tabulated in any manner desired.

23 I wish now to make some comments on the
24 contents of the brief submitted.

25 As a major premise, the Government of
26 Saskatchewan takes the view that every person in Canada,
27 regardless of economic circumstances or geographic
28 location, has the right to a uniformly high quality of
29 health services. Only by proper planning can we achieve
30 a satisfactory method of meeting the need as we have



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the Saskatchewan Registered Nurses Association as of
December 31st, 1951. As such this figure, while it is
impressive for a province of this size, does not indicate
in any way how many of these nurses are now in or would
be available for employment or, on the other hand, how
many might be lost due to a major war, for example.
It has been our intention, Mr. Chairman, that the
measurement of both physical and human resources in
the health field requires careful definition prior to
the beginning of the study.
A considerable amount of activity in
this field has been going on in the province in the past
few years, and particularly in the last two. As I have
indicated earlier, we will be working and finding out
exactly to collect for the Department and the University.
These data are
in many instances available on printed cards, and these
can be sorted and tabulated in any manner desired.
I shall now go back to some comments on the
contents of the first submission.
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regardless of economic circumstances or geographic
location, has the right to a uniformly high quality of
health services. Only by proper planning can we achieve
a satisfactory method of meeting the need as we have



1 expressed it, and, as we say in our brief, we recognize
2 there are constitutional, political -- and here I mean
3 "political" in the sense of jurisdiction over a geographic
4 area -- and organizational barriers to the realization
5 of an effective nationwide programme. It is our view,
6 however, that proper national planning requires the
7 recognition that health services must be viewed as
8 public services which can best be planned, organized,
9 administered and financed by governments at various levels,
10 each assuming their proper role.

11 Our view is, therefore, that as one
12 examines the complex and always interrelated problems of
13 health and disease and the services needed to maintain
14 one and treat the other, we inevitably come to the
15 conclusion that society can best solve its problems in
16 the health field by organized, collective action through
17 the agencies which best represent all the people, their
18 governments.

19 We do not believe that there is any
20 validity to the argument which is so often heard that
21 the development of an organizational pattern stifles
22 individual initiative. Our concept is that it is
23 necessary to create a framework of orderliness within
24 which individual initiative can have wide scope and can
25 function effectively. In the health field there are good
26 examples of programmes which have been developed in this
27 way. The highly organized hospital in which groups of
28 persons with widely differing skills work together in an
29 organizational framework which permits each individual
30 to exercise his best skills and abilities in a manner

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1 which is effective, efficient and, above all, productive
2 of satisfaction. One finds it difficult to comprehend
3 what the quality of health services might be in the
4 absence of the organized hospital. It is equally
5 difficult to comprehend frustration of the high skilled
6 individual in the absence of such a work situation. The
7 development of hospital insurance on an organized basis
8 has brought governments in the field at the level where
9 they should be brought in. This level of government
10 participation is to assure adequate financing, to over-
11 see standards of performance to the end that quality
12 is maintained in all situations, to influence the
13 development of the necessary and appropriate services
14 as well as to assure that all persons who have needs
15 can have these needs met. As we point out in paragraph
16 46 in our brief this interest and activity of government
17 does not suggest absolute control. We hold very firmly
18 to the point of view that the particular characteristics
19 of government permit various levels of government to
20 make very major contributions to the development of
21 health programmes. As I stated earlier, we in
22 Saskatchewan are very pleased and grateful to the most
23 senior level of Government in Canada for the setting up
24 of this Royal Commission. It is needless to suggest to
25 members of this Commission, but it seems desirable to
26 me for public understanding, to state that it is in-
27 conceivable that any organization or group of organiza-
28 tions outside government could have tackled the task
29 which has been given to you.

30 May I now turn to certain sections of

which is effective, efficient and, above all, productive of satisfaction. One finds it difficult to comprehend what the quality of health services might be in the absence of the organized hospital. It is equally difficult to comprehend frustration of the high skilled individual in the absence of such a work situation. The development of hospital insurance or an organized basis has brought governments in the field at the level where they should be present in. This level of government participation is to assure adequate financing, to oversee standards of performance, to insure that quality of service is maintained, and to provide for the development of the necessary and appropriate services as well as to assure that all persons who have needs can have these needs met. As we point out in paragraph 46 in our brief, such interest and solicitude of government does not suggest absolute control. We hold very firmly to the point of view that the particular characteristics of government permit various levels of government to make very major contributions to the development of health programmes. As I stated earlier, we in Saskatchewan are very pleased and grateful to the most senior level of government in Canada for the setting up of this Royal Commission. It is needless to suggest to members of this Commission, but it seems desirable to me for public understanding, to state that it is inconceivable that any organization or group of organizations outside government could have tackled the task which has been given to you.

May I now turn to certain sections of



1 the brief with a view to amplification and explanation
2 of certain of the more relevant points.

3 Beginning at paragraph 11, we suggest
4 the need to find ways and means of measuring the health
5 of the people of Canada. In evaluating our health
6 status, the techniques used to this point have been to
7 assume a certain level of healthiness by the indirect
8 method of recording illness or injury. In other words,
9 we subtract from the population of the country the
10 number who are known or identified as having illness and
11 then regard the remainder as being healthy. In times
12 of emergency such as when we examine large numbers of
13 persons to assess their health and physical status for
14 military service, we are somewhat shocked to find that
15 our state of health as a nation is lower than we have
16 assumed.

17 We believe that our society should
18 attempt to devise ways and means by which the state of
19 health can be measured. To our knowledge there has been
20 relatively little research done in this area. We
21 recognize that such an evaluation will be difficult in
22 view of the lack of known specific techniques. Our
23 suggestion to this Commission is that the real need is
24 for stimulation to be given to the various social and
25 medical disciplines to come together to try to work out
26 means of developing workable techniques. The failure
27 of our society to do this useful job may reflect our
28 lack of understanding of the need to do it, rather than
29 our inability to devise the necessary techniques.

30 Beginning with paragraph 19 we draw your

THE NATIONAL ACADEMY OF SCIENCES
OF THE UNITED STATES OF AMERICA

Beginning of paragraph 11, we suggest

the need to find ways and means of securing the health

of the people of Canada. In evaluating our health

status, the techniques used to date must have been to

assume a certain level of responsibility by the individual

method of resource illness or injury. In other words,

we subtract from the population of a country and

remains who are known or suspected of having illness and

then regard the remainder as being healthy. In times

of emergency such as when a war or large movement of

persons to assess their health and physical status for

military service, we are aware of the need to find ways

our state of health as a nation as well as what we have

assumed.

The challenge that our society should

attempt to develop ways and means of health and state of

health can be measured. To our knowledge there has been

relatively little research done in this area. We

recognize that such an evaluation will be difficult in

view of the lack of known specific techniques. Our

suggestion to this commission is that the real need is

for attention to be given to the various social and

medical disciplines to come together to try to work out

of our society to do this useful job may reflect our



1 attention to the fact that the types of diseases which
2 have major importance to our people are changing. The
3 so-called communicable diseases have diminished in
4 importance and have been replaced as major problems by
5 diseases which are much more complex, less well under-
6 stood and more difficult to prevent.

7 We suggest that there are three
8 fundamental steps which must be taken if we are to
9 develop means of preventing these diseases:

10 (1) To study their nature, occurrence
11 and end results more intensively.

12 (2) To encourage and support basic and
13 fundamental research into the nature of these diseases.



1 (3) To promote health education pro-
2 grammes which will acquaint our people with the implications
3 of disease.

4 We recommend that consideration be given
5 to means by which the level of disease and injury in
6 Canada can be more or less continually assessed. This,
7 in our view, will involve surveys and it is our opinion
8 that such surveys should be designed, organized and
9 administered on a national level.

10 I would draw particular attention to the
11 need to continually emphasize and stress the need for
12 prevention and health maintenance programmes to be
13 continued and expanded. Our belief is that such
14 programmes will only be effective to a maximum extent
15 if they are developed in an organized way. It is our
16 belief also that programmes for preventing disease can
17 best be organized under public auspices, either govern-
18 mental or through voluntary agencies and that the cost
19 should be met largely from the public purse.

20 Beginning at paragraph 27 we make two
21 basic assumptions and commend them for your consideration.
22 These are:

23 (a) Society as a whole has a concern
24 about the state of health and disease of its members,
25 and each of its members should have equal access to
26 basic and necessary services to maintain health and to
27 remedy aberrations from a state of health.

28 (b) Each member of society has a
29 responsibility to contribute towards the provision of
30 these services in a manner consistent with his ability

We recommend that consideration be given

to means by which the level of disease and injury in Canada can be more or less consistently assessed. Thus, in our view, will involve surveys and it is our opinion that such surveys should be designed, organized and administered on a national level.

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need to continually emphasize and stress the need for prevention and health maintenance programs to be continued and expanded. Our belief is that such programs will only be effective to a certain extent if they are developed in an organized way. It is our belief also that programs for preventing disease can best be organized under public health, rather than mental or through voluntary agencies and that the cost should be met largely from the public purse.

Beginning at paragraph 17 we make two

basic assumptions and comment there for your consideration

These are:

(a) Society as a whole has a concern about the state of health and disease of its members, and each of its members should have equal access to basic and necessary services to maintain health and to remedy aberrations from a state of health.

(b) Each member of society has a



1 to contribute.

2 In examining these assumptions, we suggest
3 that there are certain characteristics of health needs
4 and services which are highly relevant.

5 The first, the need for health services
6 is universal. Where treatment services are not required,
7 there still remains the need to protect the environment
8 of all of us.

9 Second, our needs and our ability to meet
10 these needs are constantly changing.

11 Third, the changing age composition of
12 our population exposes more of us to the diseases of
13 maturity which are more difficult to prevent and treat.

14 Fourth, as a consequence of the above,
15 the cost of meeting other needs has increased manyfold.

16 We next turn to discuss some of the
17 fundamental problems associated with the cost of health
18 services. It seems likely that the proportion of total
19 productivity which we assign to health care has been
20 fairly constant over the long term. Well under five per
21 cent of the gross national product is being devoted to
22 personal health services. More research in the field
23 of health economics seems to be indicated and I have no
24 doubt that the activities of this Royal Commission will
25 serve to stimulate much greater interest in this area.

26 We note that one of the crucial areas in
27 this matter of cost is whether we should consciously
28 commit a higher proportion of productivity to health
29 services. This raises the parallel question of the effect
30 of such a diversion on other sections of the economy.

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our population exposes more of us to the diseases of

maturity which are more difficult to prevent and treat.

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the cost of meeting them grows as a serious matter.

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fundamental problems associated with the cost of health

services. It seems likely that the proportion of total

productivity which we assign to health care has been

fairly constant over the long term. That under five per

cent of the gross national product is being devoted to

personal health services. More research in the field

is needed to determine whether this is a reasonable

figure. It is doubtful that the allocation of total output will

serve to stimulate much greater interest in this area.

We note that one of the crucial areas in

committing a higher proportion of productivity to health

services. This raises the parallel question of the effect

of such a diversion on other sections of the economy.



1 In Saskatchewan we have, largely as a result of the
2 development of public programmes, devoted a substantial
3 amount of our purchasing power to the health field. On a
4 per capita basis we believe that we have been one of the
5 provinces where high per capita expenditures have been made.
6 Unfortunately, comparative data are not available to us for
7 all provinces, but I quote here some of our estimated per
8 capita expenditures.

9 For the past several years, the per capita expenditure
10 for general hospital care have been the highest in Canada.
11 For 1961 tentative estimates indicate that \$45.25 per capita
12 will be spent on the operations of general hospitals. In
13 mental hospitals, expenditures in the fiscal year 1961-1962
14 amount to 10.5 millions of \$11.44 per capita. The last com-
15 parable figures available to us are for 1959 when Saskatchewan
16 spent \$9.62 per capita for mental hospitals; British Columbia
17 was next highest at \$8.22 and the national average was \$7.19.
18 In the public services we are spending in the order of \$2.50
19 per capita. Estimates of expenditures for other personal
20 health services are more difficult to make but about \$20.00
21 per capita was expended for physician services in 1959.
22 Currently the estimates for expenditures for prescribed drugs
23 is close to \$10.00 per capita.

24 THE CHAIRMAN: Is that as close a figure as you have?
25 \$10.00?

26 HON. MR. DAVIES: It is a figure I have been provided
27 with and I think we may determine later if there are any
28 better figures but this is the figure we have used and, in
29 so far as we are concerned, I believe the latest.

30 THE CHAIRMAN: That is prescribed drugs?

HON. MR. DAVIES: Prescribed drugs, yes.

development of public programmes, devoted a substantial amount of our purchasing power to the health field. On a per capita basis we believe that we have been one of the provinces where high per capita expenditures have been made. Unfortunately, comparative data are not available to us for all provinces, but I quote here some of our estimated per capita expenditures.

For the past several years, the per capita expenditures for general hospital care have been the highest in Canada. For 1961 tentative estimates indicate that \$49.25 per capita will be spent on the operations of general hospitals. In general hospitals, expenditures in the fiscal year 1961-1962 amount to 10.5 million of \$11.44 per capita. The last comparable figures available to us are for 1959 when Saskatchewan spent \$9.62 per capita for medical services, British Columbia was next highest at \$8.42 and the national average was \$7.19. In the public services we are spending in the order of \$2.50 per capita. Estimates of expenditures for other personal health services are more difficult to make but about \$10.00

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with and I think we may determine later if there are any better figures but this is the figure we have used and, in so far as we are concerned, I believe the latest.

That is prescribed drugs?

HON. MR. DAVIES: Prescribed drugs are



1 One of the chief problems in the provision of personal
2 health services is that the needs fall very unequally on in-
3 dividuals. In addition to this needs are unpredictable and
4 the costs are unwarranted and undesirable as a claim against
5 disposal be income. It seems very important to recognize that
6 expenditures for health services and particularly for meeting
7 the costs of illness or accidents threaten rather than en-
8 hance personal or family security.

9 It is our belief that the current operation
10 of our economic system in the field of health care is break-
11 ing down and that the problems inherent in providing a rational
12 programme of total health services requires a drastic re-
13 vision. Current methods of financing many aspects of health
14 care, the maldistribution of facilities and personnel, the
15 lagging supply of resources and the increased demand plus
16 the lack of coordination of services indicate the need for
17 a complete reorganization.

18 To adequately solve the complex problem we
19 require in our view a planned approach to large-scale organ-
20 ization, a suitable method of financing and a means to
21 allocate responsibilities properly.

22 May I now turn to the need for organization
23 if we are to solve the very complicated job of bringing to-
24 gether the diverse skills and resources needed to effectively
25 bring the best in health services to all people in Canada.
26 Our conclusion is that the public, through their governments
27 at all levels, have a duty to give the leadership necessary
28 to effectively organize health services. I would emphasize
29 here in the strongest possible way, that this does not mean
30 that the government has the responsibility to provide services
under detailed direction and control. Indeed as we state,
substantially different approaches will be needed in



1 meeting the problems posed in the various aspects of
2 health care.

3 Having in mind the need and desirability
4 of developing a total health programme for all the
5 people, the question arises as to how best to organize
6 such a programme. The first problem is the allocation
7 of responsibility. This, as we set out beginning at
8 paragraph 56, can be done in two ways: by the analysis
9 of the various components on the basis of interest and,
10 second, on the basis of how best to meet the costs.
11 The Government of Saskatchewan submits that the broad
12 outlines of a health services programme for all Canadians
13 must be defined on a joint federal-provincial basis
14 and the resulting programme must be financed with
15 substantial contributions from the Federal Government.
16 Such a programme must take into account the uneven
17 tax capacities of the provinces as well as their varying
18 health resources and organizations for meeting their
19 needs.

20 We do not suggest or imply that such
21 planning as will be required represents an easy task.
22 Nor do we suggest that over the long term the allocation
23 of responsibility for organizing, planning and adminis-
24 tration will be static. The developing health needs
25 and, more particularly, the developing technology and
26 the related administrative and social skills would seem
27 to argue for a flexible plan which is constantly subject
28 to review in the years ahead.

29 It is our view that the next major step
30 which should be made is to institute a nationwide



1 medical care insurance programme which is provincially
2 administered but where the content of the programme is
3 established and where substantial financial assistance
4 is provided by the Federal Government. We hold that the
5 development of a nationwide hospital insurance programme
6 is proof that we can deal effectively with the problems
7 inherent in our constitution and the varying interests
8 and methods of approach used by the provinces.

9 Such a nationwide medical care insurance
10 programme should recognize the abilities of the provinces
11 to meet the costs but, on the whole, the Federal
12 Government should assume sixty per cent of the cost.

13 In our view, hospital and medical care
14 services are the keystones to the effective development
15 of a nationwide health care service. We urge, neverthe-
16 less, that we should move towards a balanced total
17 programme which will assure the provision to all
18 Canadians of the other necessary elements. The planning
19 of ways to organize and administer programmes of drug
20 and dental benefits are extremely difficult and it is
21 our view that the means by which these can be rationally
22 attacked are not apparent. But research and study, plus a
23 considerable amount of development must go on before we
24 can move in these areas. Similarly it can be made about
25 other facets of health care.

26 In the final parts of our brief we urge
27 that mental and tuberculosis hospitals be brought under
28 the Hospital Insurance and Diagnostic Services Act and
29 that costs be shared in a manner similar to that of
30 general hospitals.



1 In the matter of training of health
2 personnel, the numbers and types of persons required will
3 be dependent upon the decisions which are reached as to
4 the emphasize to put on certain programmes. For example,
5 we have calculated that if a total and comprehensive
6 rehabilitation programme were established in Saskatchewan
7 our needs for new personnel would increase. In this
8 regard I should note that the Advisory Planning Committee
9 on Medical Care, under the chairmanship of Dr. W. P.
10 Thompson, is now completing detailed analyses of the
11 needs in a number of these fields and their report should
12 be available in due course.

13 In the field of research, we believe that
14 the major responsibility for research should be Federal
15 as it has been to the present. Provinces can do much to
16 assist in the development of research activities as has
17 this province. We urge your consideration of the
18 establishment of some form of central research authority
19 which would set out the general goals but more particular-
20 ly could provide consultation to the provincial author-
21 ities in the technical evaluation of research activities.
22 We urge as well that consideration be given to the means
23 by which research could be so financed as to create
24 incentives for more persons to equip themselves for
25 such a career.

26 In connection with the national health
27 grants programme, the Government of this Province wishes
28 to acknowledge the very real assistance that has been
29 afforded by these grants. Not only have they provided
30 financial resources, but they have also stimulated

personnel, the numbers and types of persons needed will be dependent upon the objectives which are reached as to the emphasis to put on certain programmes. For example,

our needs for new personnel would increase. In this regard I should note that the Advisory Planning Committee on Medical Care, under the chairmanship of Dr. W. F. Thompson, is now considering the need for a new type of personnel in a number of these fields and their report should be available in the near future.

In the field of research, the Bureau has the major responsibility for seeing that the research as it has been to the extent that it has been to assist in the development of research activities as well as this provided. We are going to have a section of the establishment of some form of centrally located research which would see that the general public and most particularly it could provide coordination to the professional activities in the technical evaluation of research activities. We have as well that coordination to be given to the means by which research could be so financed as to create incentives for more persons to help themselves for such a career.

groups programme, the Government of this Province wishes to acknowledge the very real assistance that has been afforded by these grants. Not only have they provided financial resources, but they have also stimulated



1 development in the specific areas to which they apply.
2 We suggest that consideration be given to the establish-
3 ment of two new grants -- one in the area of dental care
4 and one for domiciliary or home care programmes.

5 In two grants we see the need for more
6 funds being made available, the Hospital Construction
7 Grant and the Mental Health Grant.

8 Now, sir, in conclusion I would be remiss
9 if I did not emphasize most strongly that in the opinion
10 of the Government of Saskatchewan the optimum state of
11 health for all Canadians will only be achieved if we
12 effectively plan, organize, finance and administer a
13 co-ordinated total programme of health services. Our
14 approaches to date have too often been confined to find-
15 ing a method of meeting the cost of an isolated service
16 without due attention being given to other problems in-
17 herent in providing such a service. The voluntary and
18 commercial insurance plans, for example, have afforded
19 a fair measure of assistance in spreading the costs of
20 medical care among those who could afford to purchase
21 this form of insurance. These plans have never concerned
22 themselves about the need to distribute services more
23 effectively or to assure that there be any co-ordination
24 of services. When we are fighting a war against a
25 foreign enemy we have learned that only a total and co-
26 ordinated effort will be successful. In the war against
27 disease nothing less than a similar co-ordinated effort
28 will bring us the maximum results.

29 The people of Saskatchewan and the
30 Government I represent look forward in keen anticipation

and one for efficiency or time saving.

Lufta being made available, the Hospital Organization

Grant and the Mental Health Grant.

Now, first in conclusion, I would like to remind

of the Government of the United States of America, and

Health for all Americans, that we have received the

effectively plan, especially, if we are able to

co-ordinated to all programs of health services. Our

approach to have been the same, and we are going to

use a method of meeting the needs of the individual

without one attempt to bring about a change in

present in existing and a new one. The Ministry and

commercial insurance plans, for example, have offered

a fair amount of assistance in meeting the needs of

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ordinated effort will be successful. In the war against

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will bring us the maximum results.

The people of Kazakhstan and the



1 to the leadership this Royal Commission will give to all
2 Canadians in our common search for means to achieve
3 the highest possible state of health.

4 Perhaps it would not be irrelevant,
5 Mr. Chairman, if I closed this summation with a quota-
6 tion from Mr. George E. Vincent who at one time was
7 president of the Rockefeller Foundation, and this is
8 an old one, being in 1926, but if I might quote it to
9 you. He said:

10 " It looks as if society means to
11 insist upon a more effective organization
12 of medical services for all groups of
13 people, upon this distribution of costs
14 of services over large numbers of
15 families and individuals, and upon
16 making prevention of disease a control-
17 ing purpose. Just how these ends will
18 be gained only a very wise or a very
19 foolish man would venture to predict.
20 One thing seems fairly certain: in
21 the end society will have its way."

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23
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Mr. Chairman, if I closed this summation with a ques-
tion from Mr. George E. Vincent who at one time was
president of the Rockefeller Foundation, and this is
an old one, dating in 1946, but it might prove it to
you. He said:

"To look at it society means to
insist upon a more effective organization
of medical services for all groups of
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of services over large numbers of
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foolish man would venture to predict.
One thing seems fairly certain: in
the end society will have its way."



1 THE CHAIRMAN: Thank you very much,
2 Mr. Davies. We are obliged to you for this submission
3 and for the care that has gone into it, and for its
4 complete nature. We are also obliged to you and to your
5 Department for the considerable help -- any requests
6 we have made to date have been quickly and willingly
7 complied with. You have been kind enough to furnish us
8 with a copy of the Interim Report, which we have studied,
9 and we have also had co-operation from the Thompson
10 Committee, from Dr. Thompson himself, and from Mr. Sparks,
11 the Secretary, and in all of these matters the informa-
12 tion provided has been helpful and valued, and as I say,
13 we appreciate the co-operation and assistance that we
14 have had from the Minister of Health and the Department
15 and the Thompson Committee in this area.

16 Now, are there any observations that any
17 one of your associates, those associated with you here
18 this morning, wish to make at this time?

19 HON. MR. DAVIES: I think perhaps, sir,
20 that we wouldn't have any further comments at this time,
21 but these may develop as the hearing goes on.

22 THE CHAIRMAN: You appreciate that
23 you will be perfectly free to interject any comment that
24 appears to you to be relevant as the discussion, whatever
25 form it may take, proceeds.

26 Now, without wanting to reduce your
27 submission to too small a capsule, would this be putting
28 it fairly, to say that what you propose as the long-
29 term and overall proposition is a nation-wide health
30 services programme, provincially administered, but with

THE CHAIRMAN: Thank you very much.

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we appreciate the co-operation and assistance that we

have had from the Minister of Health and the Department

and the Thompson Committee in this matter.

Now, are there any considerations that any

one of your associates, those associated with you here

this morning, wish to make at this time?

HON. MR. DAVIES: I have nothing to say.

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but these may develop as the meeting goes on.

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it fairly, to say that what you propose as the long-

term and overall proposition is a nation-wide health



1 Federal assistance, which you suggest should be at the
2 ratio of about sixty per cent of the cost?

3 HON. MR. DAVIES: This, sir, might be
4 putting it in a rather small capsule, but I think
5 essentially this idea is borne out. Of course, we think
6 too in terms of health services as a totality, and not
7 bearing resemblance to assistance, say, for medical care
8 per se.

9 THE CHAIRMAN: No, I don't mean to
10 make that restriction at all, Mr. Davies. Health services
11 is the way I described it, and what I meant.

12 HON. MR. DAVIES: If you think, Mr.
13 Chairman, as you have intimated, that what we need is a
14 nation-wide approach to the whole question of providing
15 health services, and as you also indicated, we believe
16 that there should be a substantial measure of Federal
17 assistance. There is recognized, this question of un-
18 even abilities to pay, and so that we have some uniformity
19 in each aspect of the programme ----

20 THE CHAIRMAN: Is there any variation
21 in the idea of a programme that will be based, in which
22 the Federal contribution will be based on the ability of
23 the particular province in relation to the figure of
24 sixty per cent that you suggest?

25 HON. MR. DAVIES: I think this figure
26 of sixty per cent, my colleagues can correct me if I am
27 wrong on this, comes out of the 1945 Green Book Proposals.
28 I understand that at that time this figure was suggested,
29 and I think that for us in any event, in Saskatchewan,
30 that this would bear a resemblance to our needs, and to



Federal assistance, which you suggest should be at the

ratio of about sixty per cent of the cost.

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HON. MR. DAVIES: Oh, you think, Mr.

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of sixty per cent, my colleagues can correct me if I am

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and I think that for us in any event, in Saskatchewan,

that this would bear a resemblance to our needs, and to



1 equity, according to the ability of the people to pay in
2 this Province.

3 THE CHAIRMAN: If you had some uniform
4 Federal contribution of that kind, is that consistent
5 with your idea that the needs of the individual provinces
6 should be the governing factor?

7 HON. MR. DAVIES: Perhaps I omitted to
8 say on the last question, sir, that we would have no
9 objection to there being varying contributions if the
10 province had a very poor ability to pay, or for their
11 members to contribute to these plans. Otherwise I suppose
12 what would happen is that we would have too uneven an
13 organization of health services in some provinces of the
14 country, so we think that while you cannot say, of course,
15 that these health services would be precisely the same
16 in each province, because we know that for the people
17 themselves in these provinces, there needs to be that
18 type of consultation which will get from them the type
19 of services they want. Nevertheless, recognizing that
20 here there might be some uneven development and progress,
21 that we should have something in the nature of a basic
22 service, or basic provision of health services everywhere
23 in Canada, so that all Canadians would have that basic
24 service, but that there would still be a flexibility
25 within that programme, so that those that were not able
26 to come to a higher standard would be able to do so at
27 some time in the future, and that those that desired to
28 make another step would not be prohibited from making a
29 step to better health care if they chose.

30 THE CHAIRMAN: That would be within the



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here there might be some uneven development and perhaps that we should have something in the nature of a basic service, or basic provision of health services everywhere in Canada, so that all Canadians would have that basic service, but that there would still be a flexibility within that programme, so that those that were not able to come to a higher standard would be able to do so at some time in the future, and that those that desired to make another step would not be restricted.

THE CHAIRMAN: That would be within the



1 scope of the services being offered?

2 HON. MR. DAVIES: Yes, we are thinking
3 of something where the content gives a basic service
4 across Canada. This content would be something that the
5 Federal authority would need to stipulate and delineate.

6 THE CHAIRMAN: And does your programme
7 envisage that these provincial programmes, provincially
8 administered programmes, would be more or less uniform,
9 apart from this variation in content? I mean for instance,
10 your submission here is that the programme should be
11 complete, that is cover everybody and on a compulsory
12 basis?

13 HON. MR. DAVIES: Yes.

14 THE CHAIRMAN: Do you say that when
15 you advocate a nation-wide programme, do you say that
16 that should be a condition in each province as well?

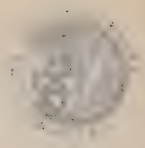
17 HON. MR. DAVIES: I am not quite sure
18 that --- are you suggesting, sir, that each province
19 would find it necessary to embark on this programme?

20 THE CHAIRMAN: No, do you say that to
21 have a nation-wide programme in your concept of things
22 that it would be administered provincially?

23 HON. MR. DAVIES: Yes.

24 THE CHAIRMAN: But that the provincial
25 programmes would have to be uniform in some respects, and
26 I am asking you if they would have to be uniform in terms
27 of universal, compulsory coverage?

28 HON. MR. DAVIES: I would say generally
29 speaking, sir, yes, and again, restating what I have said
30 before, on the basis of this fundamental content that



of the services being offered?

HON. MR. DAVIES: Yes, we are thinking

THE CHAIRMAN: And does your programme

advocate that these provincial programmes, provincially administered programmes, would be more or less uniform, apart from this variation in content? I mean for instance, your submission here is that the programme should be complete, that it covers everybody and on a compulsory

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THE CHAIRMAN: But that the provincial

programmes would have to be uniform in some respects, and I am asking you if they would have to be uniform in terms of universal, compulsory coverage?

HON. MR. DAVIES: I would say generally



1 would apply to all programmes there would be still this
2 approach that all people in each province would be part
3 of the programme, and would pay towards it according
4 to their ability to do so.

5 THE CHAIRMAN: Now, if provincial
6 consensus in that context were not forthcoming, do you
7 see that there is no nation-wide programme possible?

8 HON. MR. DAVIES: I think that if there
9 is a reluctance, or resistance by one province to
10 entering a programme of this kind, that this wouldn't
11 necessarily imply that the province would have to become
12 part of this plan, and of course, this recognizes our
13 whole constitutional framework, that we are not wanting
14 to impose on any province what some other region thinks
15 desirable, but on the other hand we think that there is
16 a Federal responsibility to give to the provinces the
17 right to develop these programmes as they are able to do
18 so, and that also they will put themselves in the
19 position of assisting these programmes in the way that
20 we have suggested in this brief, but if some province
21 refuses to be part of this framework, I don't think that
22 we would want to suggest that they be forced to be part
23 of it.

24 THE CHAIRMAN: Well, you might say then
25 that there could be what you could call a nation-wide
26 programme, but not applied to all the provinces?

27 HON. MR. DAVIES: Yes, and I think,
28 is this not, sir, exactly the experience that we have
29 encountered in the field of hospital care and assistance
30 of the Federal Government to the various provincial plans?

of the programme, and would it be better to do so
to their ability to do so.

THE CHAIRMAN: Now, it is possible

consensus in that context were not forthcoming. Do you
see that there is no nation-wide programme possible?

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is a reluctance, or resistance by one province to
entering a programme of this kind, and this would be
necessarily imply that the province would have to become
part of this plan, and of course, this requires a
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to impose on any province what some other region thinks
desirable, but on the other hand we think that there is
a Federal responsibility to give to the provinces the
right to develop these programmes as they see fit to do
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position of assisting these programmes in the way that
we have suggested in this order, but it is more probable
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we would want to suggest that they be forced to be part

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that there could be what you could call a nation-wide
programme, but not applied to all the provinces?

HON. MR. DAVIES: Yes, and I think

is this not, sir, exactly the experience that we have
encountered in the field of hospital care and assistance



1 This is the way it has worked out, and it certainly has
2 not worked out so that all of the provinces at one time
3 have decided to take the one step at the one time. They
4 have taken these steps at different times, and I think
5 we envisage something of the same sort in this context
6 here.

7 THE CHAIRMAN: Do you accept the
8 statement that the hospitalization plan, as it is working
9 now, is neither a uniform plan across Canada, nor is it
10 financed in the same way in each province?

11 HON. MR. DAVIES: Yes, there is one
12 thing, sir, I suggest that is constant, and that is
13 this measure of content. There is as we understand it
14 a measure of content required by the Federal Government
15 before contributions are made to a particular programme.

16 THE CHAIRMAN: Do you mean by that
17 certain minimum services?

18 HON. MR. DAVIES: Yes, generally.

19 THE CHAIRMAN: I am not saying minimum
20 in the term of being inadequate. I mean to say within
21 the services themselves?

22 HON. MR. DAVIES: Certain terms of
23 adequacy.

24 THE CHAIRMAN: Yes, just as for instance
25 the difference between Saskatchewan and Manitoba in the
26 amount of coverage for drug costs?

27 HON. MR. DAVIES: Right.

28 THE CHAIRMAN: Manitoba providing a
29 broader coverage in that respect than Saskatchewan.

30 HON. MR. DAVIES: I was going to remark



not worked out so that all of the provisions at one time have decided to take the one step at the one time. They have taken these steps at different times, and I think we envisage something of the same sort in this context.

THE CHAIRMAN: Do you accept the

statement that the hospitalization plan, as it is working now, is neither a uniform plan across Canada, nor is it

financed in the same way in each province?

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thing, sir, I suppose you are concerned, and that is

this measure of cost-sharing. There is no understanding of

a measure of cost-sharing required by the federal government

before contributions are made to a particular province.

THE CHAIRMAN: Do you mean by that

HON. MR. DAVIS: Yes, certainly.

THE CHAIRMAN: I am not saying anything

in the form of being a measure, I mean to say within

the provinces themselves?

HON. MR. DAVIS: Certainly, in terms of

adequacy.

the difference between Saskatchewan and Ontario in the

amount of coverage for many costs?

HON. MR. DAVIS: Right.

THE CHAIRMAN: Members providing a

broader coverage in their region than Saskatchewan



1 too, that each of the hospital plans in their own stage
2 of development will encounter different experiences. We,
3 of course, found in the earlier years of our hospital
4 plan a very marked demand, which has to some extent
5 tapered off. I suppose this will be the experience of
6 some of the other provinces that have begun their plans
7 late, but I think it is extremely important that there
8 be this measure of adequacy, or content, so that we do
9 have this basic service across the Dominion of Canada.
10 Otherwise, what you might have is some plans that did
11 not provide the service that was minimum in terms of
12 good health.

13 THE CHAIRMAN: Moving to another area,
14 you suggest that the cost of mental illness and tuber-
15 culosis, I think, but certainly mental illness, should
16 be treated the same as the cost of other illness. Now,
17 do you go along with the -- the Government of Saskatche-
18 wan, go along with the idea that the mental hospitals,
19 as we know them now, the historical mental hospital, a
20 large hospital in a more or less isolated area, is
21 passing out?

22 HON. MR. DAVIES: That is the large
23 institutionalized form?

24 THE CHAIRMAN: Yes?

25 HON. MR. DAVIES: No. As you may know,
26 sir, we do feel that the large institution in the field
27 of mental hospital care is probably passing out of the
28 picture, and we have made some moves in the direction
29 of a different type of care, thinking about the regional
30 mental hospital aspect which we have this year delayed,



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of mental hospital care is probably passing out of the
picture, and we have made some moves in the direction
mental hospital aspect which we have this year delayed,



1 but which next year we hope to make more progress on.

2 THE CHAIRMAN: That is it brings the
3 care of the patient more intimately into the local area?

4 HON. MR. DAVIES: Yes.

5 THE CHAIRMAN: And treats the patient
6 as just another ill person?

7 HON. MR. DAVIES: That is quite right,
8 sir. It establishes that illness as just another facet
9 of the whole orbit of disease, whether it is physical or
10 mental disease. Of course, we should say too that some
11 progress has been made here across the Province in the
12 psychiatric clinics that are provided as part of the
13 function of the hospital, but I think the whole concen-
14 tration is changing from the institution to this concept
15 of community care.

16 THE CHAIRMAN: Do you go so far as to
17 feel that the ultimate, ultimate as far as we can see it
18 now, situation will be either the incorporating of the
19 mentally ill person right into the general hospital, or
20 in a wing attached to the the general hospital?

21 HON. MR. DAVIES: Well, this is certain-
22 ly, sir, part of the concept. I think as we now think
23 of it, this is certainly a large part of our thinking.
24 Again, thinking changes very quickly in this field. I
25 don't think that everyone is absolutely sure about what
26 the ultimate will be, but as we see it now I think we
27 see mental illness as just another kind of illness that
28 has been approached in the community. It has to be
29 approached in a way that will find the best solution in
30 the community and will not isolate people from the area



but which next year we hope to make more progress on.

THE CHAIRMAN: That is to bring the

HON. MR. DAVIES: Yes.

THE CHAIRMAN: And focus the picture

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1 in which they live, where they receive a modern concept
2 of treatment which puts people back into the stream of
3 life more quickly than the old treatment, seems to be
4 to us the kind of approach that is logical and reasonable.

5 THE CHAIRMAN: It has been said that of two
6 patients either in the general hospital or mental
7 hospital at any given time in Canada today, one is a
8 mental patient. Is that relatively the truth in
9 Saskatchewan?

10 HON. MR. DAVIES: Excuse me, sir, I am
11 trying to get an apparently specific answer. We have in
12 our mental institutions some 3,600 patients. We have an
13 average daily patient rate of some 5,000.

14 THE CHAIRMAN: That is in the general
15 hospitals?

16 HON. MR. DAVIES: Yes, of course, this
17 last figure may change much quicker than the first.

18 THE CHAIRMAN: So, instead of being
19 one to one, it is more likely to be a ratio of three to
20 five?

21 HON. MR. DAVIES: Yes, although the
22 people in the mental institutions are moving far more
23 quickly than they used to. In one hospital there is
24 a turn-over of something like a hundred per cent of the
25 admissions. This does not mean, of course, that every
26 patient in there is turned over on that basis, so that
27 at the end of the year there will be completely different
28 personnel, but that half of those people are turning
29 over very rapidly, and this again is I understand due to
30 the more modern concepts of treatment of the mentally ill.



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over very rapidly, and this again is I understand due to
the more modern concepts of treatment of the mentally ill



1 THE CHAIRMAN: Mr. Davies, just on that
2 point. Of the 5100, is it in the general hospitals?

3 HON. MR. DAVIES: 5,000.

4 THE CHAIRMAN: How many of that number
5 would be psychiatric patients in the general hospital?
6 Let us start this way. There are some I take it?

7 HON. MR. DAVIES: Yes, there may be,
8 but how many of these people are attached to psychiatric
9 bed sections of the general hospitals, perhaps Dr. Roth
10 could help us.

11 DR. ROTH: I think, sir, it is a
12 question of who decides whether they are psychiatrics,
13 whether it is the psychiatrist or a general practitioner.

14 THE CHAIRMAN: Oh, quite.

15 DR. ROTH: There obviously are people
16 with emotional disorders in the acute general hospitals.
17 Generally speaking, the attempt is made in this Province
18 to limit the admissions to the general hospitals the
19 people who have frank psychosis, that is that can be
20 identified as such. I don't know that anyone could give
21 you the answer as to how many people there are with
22 psychoses of minor degrees in the beds of acute general
23 hospitals. Perhaps with a non-psychiatric diagnosis,
24 since this is a very tricky area.

25 THE CHAIRMAN: Are there not a number of beds
26 specifically assigned in many general hospitals as
27 psychiatric beds?

28 DR. ROTH: In this Province, sir, there
29 are four hospitals at the moment that have psychiatric
30 beds assigned to them.

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HON. MR. DAVIES: 5,000.

THE CHAIRMAN: How many of that number

would be psychiatric patients in the general hospital?

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since this is a very tricky area.

THE CHAIRMAN: Are there not a number of

specifically assigned in many general hospitals as

assigned to them.



1 THE CHAIRMAN: How many beds?

2 DR. ROTH: Thirty-nine beds in Regina.

3 There are ninety altogether. There are about thirty-two
4 in the University Hospital in Saskatoon. This varies,
5 up and down. There is a small ward at Moose Jaw, and a
6 small ward at Yorkton.

7 THE CHAIRMAN: Coming to the cost of
8 a medical care service, have you been able to estimate
9 what the cost of your programme as enacted in the
10 Saskatchewan Medical Care Insurance Act will cost for a
11 twelve-month period?

12 HON. MR. DAVIES: If my memory serves
13 correctly here, and if it doesn't I think Mr. Sparks may
14 have some figures, it would be in the order of \$20.5
15 million to \$21.0 million for the next year.

16 THE CHAIRMAN: How does the Government
17 propose to provide the money to pay that cost?

18 HON. MR. DAVIES: This is being paid
19 on the basis of three taxes: the first is on an
20 application of the income tax, so that an amount of six
21 per cent is to be applied on the tax that is to be paid,
22 as to distinguish from the taxable income. So, if a
23 person has to pay \$100.00 of income tax, he would pay an
24 additional \$6.00 on top of that.

25 THE CHAIRMAN: And that is allocated
26 for this purpose?

27 HON. MR. DAVIES: And this becomes
28 part of the medical care fund. The next tax is from the
29 sales tax which is in effect in this province. Up to the
30 time that the Medical Care Insurance Act was passed, we



1 had a three per cent sales tax, or education and health
2 tax as it is known, and we have added to this a one and a
3 half per cent portion for medical care. The other half
4 per cent that we have added to make a total of five per
5 cent as of January 1st of this year is to be applied for
6 education, as, of course, we are having some difficulties
7 financing there. So, the whole tax of five per cent is
8 in force as of January 1st, of this year, with one and a
9 half per cent going to medical care.

10 THE CHAIRMAN: Again, that will be
11 specifically allocated to that fund?

12 HON. MR. DAVIES: Allocated for that
13 purpose, yes. The third matter in which we intend to
14 finance is by personal or per capita tax of \$12.00 a year
15 for the individual and \$24.00 for the married couple,
16 this being maximum no matter whether they are a married
17 couple or with children. The per capita tax will not be
18 paid for this year in recognition of the fact the plan
19 will not be in operation until at least April 1st, which
20 was the original starting date, and the per capita tax
21 will, therefore, apply for the year following. The other
22 taxes, however, are effective as of January 1st, 1962
23 and should yield, if our expectations are correct, some-
24 thing in the order of \$20.5 million to \$21.0 million.

25 THE CHAIRMAN: And that was the figure
26 that was anticipated the plan would cost?

27 HON. MR. DAVIES: This was the figure
28 projected by the Thompson Committee and the one that we
29 have followed.

30 THE CHAIRMAN: These funds from these

2. 1st, 2nd



1 three sources, as I understand -- these taxes from these
2 three sources go into a separate fund through which pay-
3 ment for medical services will be made?

4 HON. MR. DAVIES: This is the fund
5 to pay for this service. You will recognize the sales
6 tax is an amount that comes in one chunk -- that is, five
7 per cent.

8 THE CHAIRMAN: Yes.

9 HON. MR. DAVIES: And that the
10 legislature needs to vote from that tax to the fund that
11 amount, but certainly this would be the amount made
12 available to the Medical Care Commission.

13 THE CHAIRMAN: With the intention of
14 it being one and a half per cent of the five per cent?

15 HON. MR. DAVIES: Yes, right.
16 I would also point out there is also a portion of the five
17 per cent which goes to pay for hospitalization.

18 THE CHAIRMAN: Well, three and a half
19 per cent is education and hospitalization.

20 HON. MR. DAVIES: Yes.

21 THE CHAIRMAN: But I am trying to find
22 out if there is a specific part of that five per cent
23 sales tax being set aside for medical care insurance
24 payments?

25 HON. MR. DAVIES: One and a half per
26 cent of the sum realized is voted by the legislature to
27 the Medical Care operation.

28 THE CHAIRMAN: Voted or not voted, as
29 the legislature might see fit?

30 HON. MR. DAVIES: Well, the whole thing,



1 sir, is this, that the costs of the plan are there, and
2 the control of the legislature is there, and it would be
3 a brave man, I think, who didn't make at least as much
4 money as was available from this source to the plan. If
5 it was not available, it would be, naturally and justifi-
6 ably, the kind of outcry I don't think any government
7 could bear. I rather worry about the other possibility,
8 that there may not be enough from these three taxes to
9 pay for the total amount of medical care that is provided,
10 in which case, of course, the government of the day would
11 have to face the responsibility of making the provisions
12 for that payment.

13 THE CHAIRMAN: From consolidated
14 revenue?

15 HON. MR. DAVIES: From whatever fund
16 could be determined at the moment, and if there was no
17 such fund, then the consolidated revenue fund would
18 certainly have to bear the brunt of the balance.

19 THE CHAIRMAN: Or, of course, increased
20 taxation?

21 HON. MR. DAVIES: Or, increased taxation.
22 We think the estimates that have been made, the projection
23 that has been made of costs is reasonably accurate. This,
24 I might say, is also calculated without the imposition
25 of any deterrent or utilization fees, however you wish to
26 term that, and if these were applied on the authority of
27 the Medical Care Commission, then of course the estimated
28 costs would be somewhat less.

29 THE CHAIRMAN: This type of utilization
30 fee was recommended in the interim report?

air, in this, that the costs of the plan are heavy, and the control of the Legislature is there, and it would be

could bear. I rather worry about the other possibility, that there may not be enough from those taxes to pay for the total amount of medical care that is needed, in which case, of course, the Government of the day would have to face the responsibility of making the provision.

THE CHAIRMAN: These considerations

revenue?

NO, MR. CHAIRMAN: I am not saying that could be determined at this point, and it does not, such fund, then the responsibility would have to be certainly have to bear the brunt of the balance.

taxation?

MR. CHAIRMAN: We think the estimates that have been made, the probability that has been made of course is reasonably accurate. This, I might say, is also related without the legislation

THE CHAIRMAN: This type of legislation

was recommended in the earlier report



1 HON. MR. DAVIES: You are quite right,
2 sir, yes.

3 THE CHAIRMAN: I was reading, I think
4 it is a statement by yourself, Mr. Davies -- and I may
5 be wrong in attributing this to you -- that the programme
6 which the Medical Care Insurance Act sets up is really
7 an extension of what is now in effect in the Swift
8 Current Health Unit?

9 HON. MR. DAVIES: Well, I don't know
10 whether I made that statement or not, but essentially I
11 don't think I would disagree with it. We think this is
12 an extension on a provincial basis of the same kind of
13 basis that existed in the Swift Current area. As a matter
14 of fact, we think that ultimately there can very well be
15 a regionalization of medical care administration or
16 handling.

17 THE CHAIRMAN: I didn't want to take
18 you too far along the way. It was merely for the purpose
19 of bringing to your attention another matter: as I
20 understand it, the basic proposition in the Swift Current
21 Health Unit is that a fund is created from which the
22 services are paid. It is created by taxation and by
23 contributions -- that there is a fund of \$X becomes
24 available in any given year for the payment of services;
25 is that right?

26 HON. MR. DAVIES: I will ask Dr. Roth
27 to answer that.

28 DR. ROTH: No, sir. This is no longer
29 correct. This was formerly the way ---

30 THE CHAIRMAN: "No longer" -- since



HON. MR. DAVIES: You are quite right.

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services are paid. It is created by taxation and by

contributions -- that there is a fund of \$100,000

available in any given year for the payment of services.

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HON. MR. DAVIES: I will say that that

MR. HOFFER: No, sir. This is no longer

correct. This was formerly the way --

THE CHAIRMAN: "No longer" -- since



1 what time?

2 DR. ROTH: I may have misinterpreted
3 your question. I thought you meant in terms of funds
4 that there was a certain pot of money or pool of money
5 available and that this was pro-rated among the physicians
6 in the area.

7 THE CHAIRMAN: That is one of the
8 ideas I wanted to ask about.

9 DR. ROTH: Well, the Swift Current
10 region now agrees to pay a percentage of the schedule of
11 fees, and there is no further pro-ration beyond this.

12 THE CHAIRMAN: What do you mean by
13 "agrees"?

14 DR. ROTH: Agrees with the physicians
15 in the area; that is, the Swift Current Regional Board
16 signs a memorandum of agreement with the district medical
17 society and contracts with each physician in the area,
18 on a personal contract between the physician and the
19 Board, and then -----

20 THE CHAIRMAN: And what is that per-
21 centage?

22 DR. ROTH: It is eighty-five per cent
23 of the schedule of fees less a utilization fee that is
24 charged, a specific utilization fee which is charged on
25 home and office calls. In other words, I may have mis-
26 interpreted your question, but at one time there was a
27 pool of money which was pro-rated, and when that ran out
28 there was no more money. This is no longer true. The
29 Swift Current Regional Health Board may obligate itself
30 to a deficit any time and have a reserve fund set up to



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MR. ROBIN: I may have misinterpreted your question. I thought you meant in terms of funds that there was a certain pot of money or pool of money available and that this was granted among the projects in the area.

THE CHAIRMAN: That is one of the ideas I wanted to ask about.

MR. ROBIN: Well, the Swiss Government region now agrees to pay a percentage of the salaries of teachers, and there is no financial contribution beyond this.

THE CHAIRMAN: What do you mean by

MR. ROBIN: I propose with the physician in the area; that is, the Swiss Government would sign a memorandum of agreement with the physician and the society and contribute with each physician in the area on a personal contract between the physician and the Board, and then

THE CHAIRMAN: And what is that?

MR. ROBIN: It is difficult for you to see of the schedule of fees fees a contribution fee that is charged, a specific contribution fee which is charged on home and office calls. In other words, I may have interpreted your question, but at the time there was a pool of money which was provided, and when that ran out there was no more money. This is no longer true. The Swiss Government National Health Board may contribute to a deficit any time and have a reserve fund set up to



1 take care of this.

2 THE CHAIRMAN: In terms of what the
3 Saskatchewan programme may cost, can you tell me if
4 calculations have been made to determine what the cost
5 will be to a married couple with, say, two dependents,
6 with an income of, say, \$3,000.00?

7 HON. MR. DAVIES: Well, this is rather
8 difficult to give any precise figure on, Mr. Chairman,
9 for obvious reasons, that the payment of sales tax will
10 vary, but we have, I think, thought of some rough
11 calculations in terms of this kind of family. Looking at
12 the D.B.S. pattern of family spending --- I think you
13 may be familiar with this; it delineates families in
14 different groups and arranges in sections the spending
15 they have for food, clothing, shelter, etcetera, and on
16 the basis of what they spend you can arrive at some very
17 rough estimates. If a person buys a car, this is going
18 to be something very different indeed, but at the
19 \$3,000.00 income, the amount of income tax paid by a
20 married man with two children would, I think, be either
21 nil or a dollar or two more. I think with two children
22 you would find he would not pay anything more in income
23 tax for the service. He might pay income tax, but he
24 would not pay income tax for this service.

25 THE CHAIRMAN: If he paid any income
26 tax at all, he will pay six per cent more?

27 HON. MR. DAVIES: Yes, that is quite
28 right, but as between \$2,500.00 and \$3,000.00 income,
29 the amount of taxes that a married man with two children
30 would pay would be either nil or very little. So, really



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the amount of taxes that a married man with two children

would pay would be either nil or very little. Not really



1 no income tax would be applicable there.

2 THE CHAIRMAN: Well, at the \$4,000.00
3 level?

4 HON. MR. DAVIES: If I may proceed
5 with the first example on the other two taxes. The one
6 and a half per cent application on sales tax, with a
7 family earning \$3,000.00 a year, again on this basis of
8 the family spending would, I think, yield something
9 between \$16.00 or \$18.00 yearly extra from this one and a
10 half per cent portion. It may be somewhat less; I think
11 I have perhaps over-emphasized it. Finally, of course,
12 the \$12.00 and \$24.00 applications would be constant.
13 So that if one wants to take for this family, even if we
14 take as high as \$20.00 for the extra sales tax, and the
15 \$24.00, and assuming there was no extra income tax paid,
16 this family would be paying \$44.00. It has been estimated
17 on the basis of this sort of figure that some eighty
18 per cent of the families in Saskatchewan might pay less
19 than they are paying now under the private plan, and
20 I am not saying these figures are completely precise or
21 accurate, but they are a projection of some estimates
22 that you can make under these broad assumptions.

23 THE CHAIRMAN: Could you project that
24 through \$4,000.00, \$5,000.00, \$6,000.00, and so forth,
25 in \$1,000.00 steps up to, say, \$15,000.00?

26 HON. MR. DAVIES: I think what we
27 could do on this is provide the Commission with a table
28 -- the kind of table I am speaking about--- of these
29 estimates for all levels of income. If I remember
30 correctly, as one got to the \$6,000.00 or \$7,000.00 a



Davies

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no income tax would be applicable there.

THE CHAIRMAN: Well, at the \$4,000.00

with the first example on the other two taxes. The one
 and a half per cent application on sales tax, with a
 family earning \$3,000.00 a year, again on this basis of
 the family spending would, I think, yield something
 between \$10.00 or \$15.00 yearly extra from this one and a
 half per cent portion. It may be somewhat less; I think
 I have perhaps over-emphasized it. Finally, of course,
 the \$12.00 and \$24.00 applications would be constant.
 So that if one wants to take for this family, even if we
 take as high as \$20.00 for the extra sales tax, and the
 \$4.00, and assuming there was no extra income tax paid,
 this family would be paying \$24.00. It has been estimated
 on the basis of this sort of figure that some eighty
 per cent of the families in Saskatchewan might pay less
 than they are paying now under the present plan, and
 I am not saying these figures are completely precise or
 accurate, but they are a projection of some estimates
 that you can make under these broad assumptions.

THE CHAIRMAN: Could you project that

through \$4,000.00, \$5,000.00, \$6,000.00, and so forth,
 in \$1,000.00 steps up to, say, \$15,000.00?

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could do on this is provide the Commission with a table
 -- the kind of table I am speaking about -- of these
 estimates for all levels of income. If I remember
 correctly, as one got to the \$6,000.00 or \$7,000.00 a



1 year income you would find they would pay the same or
2 a little more than they now do under the private plans,
3 remembering, of course, as we see it, there will be some
4 additional services provided also because of the
5 comprehensive nature of the plan. However, our
6 philosophy is this, that as matters now stand under
7 private plans, you will pay the same whether you are
8 making \$30,000.00 a year or \$3,000.00. We don't think
9 that in equity this can hold up, and the assumption,
10 therefore, is that if you have a higher income you will
11 pay somewhat more for medical care.

12 THE CHAIRMAN: When you do come to
13 the time at, say, the \$6,000.00 or \$7,000.00 level when
14 a person will be paying \$75.00 to \$100.00 by way of this
15 income tax sur-charge -- additional to the \$24.00 and
16 additional to the one and a half per cent?

17 HON. MR. DAVIES: I don't think he
18 will be paying \$75.00 of income tax at those ranges; but
19 I say that on the basis of all taxes, assuming this
20 normal family spending and so forth, that the totality
21 of your cost would be either the same or somewhat more
22 at the \$6,000.00 or \$7,000.00 a year income. Again,
23 this does not apply if you have bought a car.

24 THE CHAIRMAN: If that is a year in
25 which you buy a car, you pay a lot more?

26 HON. MR. DAVIES: That is right.

27 THE CHAIRMAN: Is this correct, that
28 regardless of how much you may contribute, that the
29 individual resident may contribute by this one and a half
30 per cent or by the income tax sur-charge, if the premium
is not paid he is not an insured person?



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additional services provided also because of the

comprehensive nature of the plan. However, our

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private plans, you will pay the same whether you are

making \$30,000.00 a year or \$3,000.00. We don't think

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therefore, is that if you have a higher income you will

pay somewhat more for medical care.

THE CHAIRMAN: Then you do come to

the time at, say, the \$6,000.00 or \$7,000.00 level when

a person will be paying \$75.00 to \$100.00 by way of rate

income tax sur-charge -- additional to the \$24.00 and

additional to one and a half per cent.

MR. DAVIES: I don't think it

will be paying \$75.00 of income tax at those ranges; but

I say that on the basis of all taxes, assuming this

normal family spending and so forth, that the totality

of your cost would be either the same or somewhat more

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this does not apply if you have bought a car.

THE CHAIRMAN: If that is a year in

which you pay a car, you pay a lot more?

MR. DAVIES: That is right.

THE CHAIRMAN: Is that correct, that

individual resident may contribute by this one and a half

per cent or by the income tax sur-charge, if the premium



1 HON. MR. DAVIES: We have followed
2 that philosophy with the hospitalization.

3 THE CHAIRMAN: Is that the fact?

4 HON. MR. DAVIES: Your entitlement is
5 you should have a hospital card but if you are unable to
6 pay for the card then provision is made to pay it for
7 you.

8 THE CHAIRMAN: If you would not mind
9 dealing with this specific question.

10 HON. MR. DAVIES: Perhaps I misunder-
11 stood you.

12 THE CHAIRMAN: If you are liable to
13 pay a premium and if you do not pay that premium regard-
14 less of how much your contribution may have been from
15 these other sources you are not an insured person?

16 HON. MR. DAVIES: To pay his personal
17 tax, to ensure full entitlement?

18 THE CHAIRMAN: To ensure any entitle-
19 ment, is it not?

20 HON. MR. DAVIES: Yes, but I wanted
21 to emphasize without appearing to equivocate.

22 THE CHAIRMAN: There is no suggestion
23 you were.

24 HON. MR. DAVIES: There are means by
25 which those who are unable to pay are able to get this
26 paid for them.

27 THE CHAIRMAN: Then, I want to revert
28 to Swift Current; would you be in a position to furnish
29 the Commission with the financial annual reports of the
30 Swift Current area for the years 1955 to date?

that philosophy with the hospitalization.

THE CHAIRMAN: Is that the first?

HON. MR. DAVIES: Your second question is

you should have a hospital card but if you are unable to

pay for the card then provision is made to pay it for

THE CHAIRMAN: If you wouldn't mind

dealing with this specific question.

HON. MR. DAVIES: If you are unable to

pay a premium and if you do not want premium paid

less of how much your contribution will be paid for.

These other answers you are not in a position to

HON. MR. DAVIES: To pay for premium

that, to speak of it on the ground

ment, as it is

HON. MR. DAVIES: Yes, but I wanted

to emphasize without appearing to deny

you were.

HON. MR. DAVIES: There are people in

which those who are unable to pay are able to get help

paid for them.

THE CHAIRMAN: That, I want to know

to Swift Company: Would you be in a position to find

the Swift Company for the years 1955 to 1956?



1 HON. MR. DAVIES: Yes, sir.

2 THE CHAIRMAN: I do not know if you
3 are familiar with the proposal that is put forward to
4 this Commission by the Government of Manitoba just last
5 week which foresees a coverage, complete coverage in the
6 Province of Manitoba of those who wish coverage on a
7 voluntary basis with the government contributing to bring
8 the premium down to a level at which it is said every-
9 body would be able to pay, and then, of course, with the
10 government paying the premium for all those who are in
11 fact unable to pay. Essentially it appears to be that
12 the Manitoba proposal is on a voluntary basis whereas
13 the Saskatchewan programme is on a compulsory all-
14 inclusive basis.

15 HON. MR. DAVIES: I am not familiar
16 with the proposal, I did not read the brief, but just
17 as you have outlined it I think I see their proposal.

18 THE CHAIRMAN: We put this question
19 to the Manitoba Government and we now put it to you:
20 what is the essential difference if all are covered
21 whether it is done on a voluntary basis or on a compul-
22 sory basis?

23 HON. MR. DAVIES: May I ask one
24 question before attempting to answer this? As I under-
25 stand this, it is essentially subsidization of private
26 plans, is it?

27 THE CHAIRMAN: Subsidization of private
28 plans, yes.

29 HON. MR. DAVIES: Well, I think we
30 would say rather categorically that we do not believe



1 that this kind of an arrangement will guarantee to the
2 people this concept of overall health that we have tried
3 to project in our brief. We think essentially what you
4 will do is simply bonus a private plan which again is
5 not a plan that is run by the people by any area of
6 government, and should be able it to finance better but
7 not enable it to provide health care better. This type
8 of health plan is not interested in a whole scope of
9 things. Simply it means there can be some relatively
10 large segments of the population that are not covered at
11 all and this means that you have bad cavities, as it
12 were, in the health state you are trying to build. We
13 do not think this is a kind of an arrangement that you
14 can have in terms of subsidization of private plans. We
15 think this philosophy has to be rejected. I think that
16 the Thompson Committee, to shorten my remarks and not
17 attempt to describe it fully but in a particular section
18 said that they think this is not a satisfactory basis
19 of providing the kind of care that the public has a right
20 to expect.

21 THE CHAIRMAN: The majority report?

22 HON. MR. DAVIES: Yes, in terms of
23 the majority report.

24 THE CHAIRMAN: Now, going back: if
25 the mental patient becomes a patient of the general
26 hospital I suppose we have to accept the proposition that
27 it would be much more costly then at that present time?

28 HON. MR. DAVIES: Well, it may be
29 more costly, sir, but I do not think necessarily as
30 costly as what general hospital care now is. After all,

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Hon. Mr. DAVIS: Well, it may be
more costly, sir, but I do not think necessarily so
costly as what general hospital care now is. After all,



1 in general hospitals I know it has been suggested that
2 the hospitals are the same as the mental hospitals in
3 this respect or should be. In the general hospitals we
4 have to provide a complete range of services that are
5 not required in the mental hospitals so to care for a
6 whole variety of reasons hinged to the services is more
7 costly in the general hospital than in the mental
8 institution.

9 THE CHAIRMAN: Is it in the order of
10 something around \$20.00 a day in the general hospital as
11 compared to \$4.00 or \$5.00 in the mental hospital?

12 HON. MR. DAVIES: No, our charge in
13 the mental hospital is somewhat greater than that;
14 \$5. 54 is our charge in the mental hospital, and I
15 suppose you can run up as high as \$20.00 or somewhat
16 better in the general hospitals. However, here again I
17 suggest that the type of treatment required is what makes
18 the expense.

19 THE CHAIRMAN: That is quite true but
20 in the bringing together of the mental and the general
21 patient is bound to be reflected in increased costs. I
22 am not saying it will double the cost but you are bound
23 to have increased cost, are you not?

24 HON. MR. DAVIES: Well, again I say
25 there may be, but we do not feel that this necessarily
26 follows for the reasons I have suggested, that the type
27 of treatment is necessarily much more expensive in a
28 general hospital than in a mental institution.

29 THE CHAIRMAN: Have you got the figure
30 on the costs in a chronic hospital in Saskatchewan?



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whole variety of reasons related to the services is more
costly in the general hospital than in the mental

THE CHAIRMAN: Is it in the order of
something around \$10.00 a day in the general hospital as
compared to \$4.00 or \$5.00 in the mental hospital?
MR. DAVIES: No, our charge in
the mental hospital is somewhat greater than that.
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there may be, but we do not feel that this necessarily
follows for the reasons I have suggested, that the type
of treatment is necessarily much more expensive in a
general hospital than in a mental institution.

THE CHAIRMAN: Have you got the figure



1 DR. ROTH: I think this needs some
2 definition because there are chronic hospitals and chronic
3 hospitals. For instances, in the geriatric centres which
4 are operated by the Department of Welfare in this Province
5 and which give quite an intensive level of treatment,
6 that is people are, generally speaking, fairly seriously
7 ill requiring high amounts of medical and nursing care,
8 and they are a class of patients where there is an
9 attempt to rehabilitate them. The costs are higher in
10 a chronic hospital which is purely custodial for people
11 where all efforts have failed and where just ordinary
12 good nursing care is being given. The geriatric hospitals
13 are moving up towards \$7.00 per day. There are some
14 of the chronic hospitals which get into the nursing home
15 category which are considerably less costly than this.
16 We do not have the figures on this since in this province
17 that type of hospital comes under the Department of
18 Welfare, but we could get the figures for you. Again,
19 it varies with the amount of service you get.

20 THE CHAIRMAN: If you will be good
21 enough to provide us with those figures it may be of some
22 help.

23 DR. ROTH: We will try and define in
24 a general way what the service is.

25 COMMISSIONER VAN WART: Mr. Davies,
26 I do not intend to go into the philosophy of what you
27 have expounded to us at all but to pick out just a few
28 items or detail in your brief for a little elaboration
29 and for our information.

30 First of all, on page 8 under section C

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that type of hospital under the Department of

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and for our information.

First of all, on page 5 under section 1



1 I can sum it up why you feel that there should be a
2 great increase in health education is needed to develop
3 better public understanding of major disease entities.
4 In considering this do you think the health education
5 should be Federal or provincial level or both or what is
6 your conception of that?

7 HON. MR. DAVIES: I would think both.
8 That is, there is a great deal to be said for a co-
9 ordinated approach to health education, and I think it
10 is extremely valuable to have a provincial involvement,
11 even a local involvement perhaps, but again, this should
12 be as a result of co-ordination of governmental approach
13 so what is sought to be done can be done best by all
14 working together.

15 COMMISSIONER VAN WART: Could you
16 subsequently submit to us what you visualize under a
17 programme of health education?

18 HON. MR. DAVIES: We would be very
19 pleased to do so. I think you know that we do have a
20 health education branch in our own department and it may
21 be that our director of this branch will be able to give
22 you something in the hearings in a very informal way
23 perhaps, but it will describe what he and his associates
24 have been able to do in this field. I think he will be
25 very glad to give you information as to how a health
26 education programme can be developed and projected in the
27 kind of framework that we are trying to suggest.

28 COMMISSIONER VAN WART: Also on page 8
29 you suggest there may be some form of national survey of
30 health and disease and going to page 9 you recommend that



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education programme can be developed and presented in the
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COMMISSIONER VAN WART: Also on page 2
you suggest there may be some form of national survey of
health and disease and going to page 3 you recommend that



1 the analysis be done on provincial basis. Have you the
2 facilities in the province to make a suitable statistical
3 analysis of such a survey as that?

4 HON. MR. DAVIES: We suggest here that
5 we want to see a recording, an analysis of data done on
6 a provincial basis so that the data would be available
7 for provincial planning. We are thinking here of
8 insuring in whatever framework we have that the province
9 will be available to do whatever figures are given in
10 whatever way it may be, and an arrangement will be worked
11 out between the provinces of the Dominion where a more
12 centralized form of statistical gathering might be
13 accomplished. But, we would like to see if this was done
14 that each of the provinces was able to get this type of
15 data and this type of information for its own particular
16 use. You see, you can have the kind of arrangement
17 where you have some very good figures for national
18 purposes but these figures do not suit the provincial
19 purposes. Here we are thinking of an inter-related and
20 inter-dependent type of thing.

21 COMMISSIONER VAN WART: And the next
22 question is on page 30, paragraph 79:

23 "It is our contention that mental and
24 tuberculosis hospitals should be brought under
25 the Hospital Insurance and Diagnostic Services
26 Act and the costs shared in a manner similar
27 to general hospitals."

28 Have you any estimates or could you
29 give us the estimates of what the overall picture would
30 be, the costs for those two projects and submit it?



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COMMISSIONER VAN WART: And the next question is on page 30, paragraph 79:

"It is our contention that mental and tuberculosis hospitals should be brought under act and the costs shared in a manner similar to general hospitals."

Have you any estimates or could you give us the estimates of what the overall figures would be, the costs for these two projects and submit it?



1 You mentioned earlier in your brief the per capita rate
2 but I was thinking more in the terms of the overall
3 costs.

4 HON. MR. DAVIES: For the province?

5 COMMISSIONER VAN WART: For the
6 province, yes.

7 HON. MR. DAVIES: The cost for our
8 last available figures --- I guess this simply means
9 a little bit of division--for sanatoria care was just
10 about \$2 million, a little over, I think. \$10.5
11 million for our mental hospitals so that we have here
12 some \$12.5 million that we are suggesting as a cost
13 that should be shared in the same framework as we have
14 sharable expense in hospital care.

15 COMMISSIONER VAN WART: But in the
16 future the figures will be much higher for the mental.
17 Have you any projected figures of what it will cost in
18 the future?

19 HON. MR. DAVIES: Well, I do not
20 know that we can give you a projection now. We would
21 be glad to attempt it but I would like to point out that
22 the expenses for sanatoria is going down. There will
23 be a closing of another institution; formerly there
24 were three and one has closed down, and we now use
25 this institution for our mental care programme. It is
26 felt that before the end of this year there will be
27 another institution closed which will leave only one
28 of them. This speaks well for the programme which had
29 been developed not simply by the Government but in
30 co-operation with many municipalities and organizations.



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1 THE CHAIRMAN: That is a common
2 procedure now pretty well from one end of Canada to
3 the other with these tuberculosis sanatoria.

4 HON. MR. DAVIES: I think progress
5 is being made everywhere.

6 THE CHAIRMAN: We heard of
7 remarkable progress in Newfoundland in that respect.

8 HON. MR. DAVIES: I wonder if I
9 could interrupt? How far would you like to have that
10 projection of costs?

11 COMMISSIONER VAN WART: I would
12 like to know what you visualize the ultimate cost would
13 be to give you an adequate mental health service.

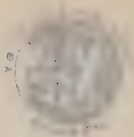
14 THE CHAIRMAN: Mr. Davies wants to
15 know what "ultimate" is.

16 COMMISSIONER VAN WART: Say, a
17 ten year programme.

18 HON. MR. DAVIES: We can attempt
19 that.

20 COMMISSIONER VAN WART: Number
21 eighty, you state health service programme will be
22 successful only if persons who provide the services are
23 available in sufficient numbers with sufficient skills
24 and so on. Then when you come to your summary you
25 mention that the Commission is undertaking a study and
26 you offer to participate in such a study and make
27 certain specific suggestions. I said we would welcome
28 those suggestions in detail.

29 HON. MR. DAVIES: We would certainly
30 be glad to do this at the time this study is undertaken.



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procedure now, pretty well from one end of Canada to

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be glad to do this at the time this study is undertaken.



1 COMMISSIONER VAN WART: Then at
2 eighty-three you state:

3 "We believe that in the coming
4 years it will be most essential for
5 Canada to develop a group of persons
6 with sound academic training and some
7 practical experience in the adminis-
8 tration of a variety of health
9 programmes, particularly in the field
10 of medical care insurance."

11 Am I to assume that there is a lack
12 of personnel at the present time for the administration
13 of an adequate medical care programme or just what do
14 you have in mind for that statement?

15 HON. MR. DAVIES: Well, I think
16 you could say generally that we do think that there is
17 a scarcity of this type of person, for the plain reason,
18 Doctor, that we haven't explored this field
19 sufficiently. As time goes on, I think we will have
20 more and more people that understand and have the know-
21 how for this particular field, but we think, at the
22 moment, there is some scarcity in this field.

23 I know that Dr. Roth has some fairly
24 coherent ideas on this, and in fact, shortly after the
25 first of the month of July, will be embarking on the
26 kind of undertaking that will supply more administrators
27 in the whole field of health, and I hope, at that time,
28 that we will have administrators provided for in the
29 field of medical care insurance.

30 Probably up to this time, the



Davies

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of medical care insurance."

And I to assume that there is a lack

of personnel at the present time for the administration

of an adequate medical care programme or just what do

you have in mind for that statement?

HON. MR. DAVIES: Well, I think

you could say generally that we do think that there is

a scarcity of this type of person, for the plain reason

Doctor, that we haven't explored this field

sufficiently. As time goes on, I think we will have

more and more people that understand and have the know-

how for this particular field, but we think, at the

moment, there is some scarcity in this field.

I know that Mr. Van Wart has some fairly

coherent ideas on this, and in fact, shortly after the

first of the month of July, will be embarking on the

kind of undertaking that will supply more administrators

in the whole field of health, and I hope, at that time,

that we will have administrators provided for in the

field of medical care insurance.

Probably up to this time, the



1 experience that has been had is mainly in the private
2 plan, although there is some experience where public
3 plans have been operating.

4 COMMISSIONER VAN WART: You will
5 be able to submit to us your ideas on the type of
6 personnel that should be trained, etcetera?

7 HON. MR. DAVIES: Yes. I think we
8 would, but we are thinking here of setting up the kind
9 of programme that will produce this type of personnel.
10 We are not sure that we know all the components that
11 enter into it. Probably as medical care programmes
12 grow, there will be more persons with the pragmatic
13 know-how, but, of course, this should be supplemented
14 with the kind of thing you get in classes and advanced
15 courses and so on, but it seems to us that there are
16 not enough of this class of persons at the moment.

17 COMMISSIONER VAN WART: Turning
18 to page 34, section 93, with regard to the increase
19 in the Hospital Construction Grant. Would you give
20 us some ideas of the lack in acute, convalescent,
21 chronic and psychiatric beds, and the number that are
22 needed, and the cost of those?

23 HON. MR. DAVIES: Are you think-
24 ing only of the beds for the treatment of mental patients,
25 Doctor?

26 COMMISSIONER VAN WART: No. This
27 is in your 33, the Hospital Construction Grant. You
28 recommend that there be an increase in the Federal
29 Government grants, and will you just give us some idea
30 of what your needs are?



Davis

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COMMISSIONER VAN WART: No. This

is in your 35, the Hospital Construction Grant. You

recommend that there be an increase in the number

Government grants, and will you just give us some idea

of what your needs are?



1 HON. MR. DAVIES: Excuse me,
2 Doctor. Could you repeat your question?

3 COMMISSIONER VAN WART: It is in
4 section 93.

5 HON. MR. DAVIES: I think that is
6 being asked is really, what is our projected need?

7 COMMISSIONER VAN WART: Yes.

8 HON. MR. DAVIES: We have
9 currently an investigation going on by our Hospital
10 Survey Committee. This has not reported yet.
11 It is expected to report this year, I hope in a few
12 months, and the survey should show what we want though,
13 and that is just where does need exist, and is there
14 in fact need in some quarters where some people think
15 there is a rather desperate need.

16 I would point out, of course, that
17 we have a considerable number of hospital beds at the
18 moment. I believe our average is the highest in Canada.
19 and if you wish I can tell you about our present basis
20 of grants as well.

21 COMMISSIONER VAN WART: Yes?

22 HON. MR. DAVIES: At the present
23 time, Mr. Chairman and Doctor, we have a situation
24 where the Federal Government contributes \$2,000.00 a
25 bed, but we feel that the average cost of hospital beds
26 in the Province is something between \$13,000.00 and
27 \$15,000.00 a bed. Now, moreover, under Saskatchewan's
28 new construction grant-sharing formula with local
29 communities, the Province will pay a maximum of
30 \$9,100.00 a bed for a base hospital, or interpreting it

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of grants as well.

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\$9,100.00 a bed for a base hospital, or interestingly



1 in another way, seventy per cent of the cost less the
2 Federal Grant of \$2,000.00. We pay \$6,600.00 on the
3 cost of the regional hospital bed up to a maximum
4 cost of \$13,000.00 or sixty per cent of total cost less
5 the Federal Grant, again, and \$3,200.00 on the cost of
6 a community hospital up to \$10,000.00, or forty per
7 cent of the total cost, less again, the Federal Grant.

8 Now, prior to this very substantial
9 increase in provincial contributions to construction
10 costs, that was before September of 1960, the Federal
11 and Provincial Governments were contributing only
12 \$2,000.00 each per bed, so that the provincial
13 contributions have at this time very substantially
14 increased in relation to the Federal contributions.

15 THE CHAIRMAN: That is, you
16 require the local community in whatever form it takes
17 to contribute thirty per cent of the capital cost of
18 the hospital?

19 HON. MR. DAVIES: Yes, dependent
20 on what type of hospital, the percentage varies.

21 THE CHAIRMAN: But that is the
22 maximum?

23 HON. MR. DAVIES: Yes.

24 THE CHAIRMAN: At the highest
25 level the local community must contribute thirty per
26 cent?

27 HON. MR. DAVIES: Correct.

28 THE CHAIRMAN: As we heard in
29 Manitoba last week, that Manitoba required a twenty
30 per cent contribution.



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Manitoba last week, that Manitoba required a twenty



1 COMMISSIONER VAN WART: In para-
2 graph 94, you urge that the increase in the Mental
3 Health Grant needs are great, and these are urgent do you
4 think?

5 . HON. MR. DAVIES: Yes, we think they
6 are quite urgent, sir.

7 COMMISSIONER VAN WART: And I
8 wonder if when you are making your submission that you
9 could give us the cost of what you think would come under
10 that heading?

11 HON. MR. DAVIES: Yes, we would be
12 glad to.

13 COMMISSIONER VAN WART: I under-
14 stand you are having a Committee surveying the aged,
15 long-term illnesses, is that correct?

16 HON. MR. DAVIES: That is right.

17 COMMISSIONER VAN WART: Will that
18 report be made available to us?

19 HON. MR. DAVIES: We will be glad
20 to make it available, just as soon as it is released.

21 COMMISSIONER VAN WART: Is that
22 expected in the near future, or at some distant date?

23 HON. MR. DAVIES: Our target date
24 now is September 1st.

25 COMMISSIONER VAN WART: And I
26 suppose that report will include the costs of the
27 recommendations will it?

28 HON. MR. DAVIES: I am not sure
29 whether it will or not, but if it does not, we will
30 attempt to supplement the information, as you have



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1 requested.

2 COMMISSIONER VAN WART: Thank you.

3 You would expect the above improvements in the present
4 mental health programmes, hospital construction, and
5 also rehabilitation and the care of the aged, to cost
6 considerable money, would you not, for the improvements?

7 HON. MR. DAVIES: There is no deny-
8 ing that, sir.

9 COMMISSIONER VAN WART: You would
10 expect it to cost more than the medical service care
11 programme you are inaugurating at the present time?

12 HON. MR. DAVIES: I would rather
13 not give any estimate of that. It is very difficult
14 to talk about expectations when you don't have any
15 very precise figures to go on. Hazarding a guess,
16 I should think that this should not cost as much, but
17 I might be wrong in my analysis.

18 COMMISSIONER VAN WART: That was
19 one of the reasons why I asked you to submit the figures
20 to us, because I have the feeling that it would cost
21 much more than \$20 million to carry out all these
22 improvements in these things.

23 HON. MR. DAVIES: One of the
24 reasons why we didn't attempt to supply a figure here,
25 Mr. Chairman, was because it was very difficult to
26 know exactly what the Commission wanted in terms of
27 pinpointed information, and we are very glad to have
28 these suggestions, and we will be very glad to supply
29 the information you have asked for, so that the
30 Commission will have the fullest type of information



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1 on which to base recommendations.

2 COMMISSIONER VAN WART: And you
3 would consider all these expectations are fairly urgent,
4 I mean, as things of the distant, in the next ten years
5 or so you expect to inaugurate these things?

6 HON. MR. DAVIES: We would like
7 to get to them as rapidly as possible. It all depends
8 on a great many things, sir, as you know.

9 COMMISSIONER VAN WART: You, in
10 your philosophy considered the medical services that
11 were more urgent than these?

12 HON. MR. DAVIES: Yes. We think
13 that is the programme that should be instituted now,
14 and in terms of priority, it appears to us that we
15 have done a reasonably adequate job in the provision
16 of other services, so that the provision of this new
17 service now isn't something in the nature of the cart
18 before the horse. In other words, we think it is in
19 time, and referring, of course, to expenditures like
20 mental hospital expenditures, we point out that on the
21 last available figures, Saskatchewan had the highest
22 per capita cost of this kind of care.

23 COMMISSIONER VAN WART: Do you
24 realize that in some other provinces they may not
25 consider the medical services have more priority than
26 these? Would you express to us in your subsequent
27 submission your reasons why you think it should have
28 priority over these other things?



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1 HON. MR. DAVIES: Well, do you mean
2 why we think this should take priority over what other
3 people recommend?

4 COMMISSIONER VAN WART: Yes?

5 HON. MR. DAVIES: Well, in the
6 first instance, of course, I don't know what actuates the
7 reasoning of other people in other provinces. We
8 think that the orbit of medical care plainly is the
9 orbit that people are primarily interested in, and it
10 seems to me indicated plainly as the first action in
11 the full provision of all these things that go to make
12 up good health. I think it is in the Thompson
13 Committee report that they discussed the feasibility
14 and the desirability of getting other services going
15 as fast as this can be done after the inauguration of
16 this type of plan. But certainly this is the thing
17 that should be primary.

18 Naturally, there are other areas
19 as well, the provision of drugs, the provision of
20 dental services, and the provision of home nursing care.
21 All of these are obviously areas that we are looking
22 to in the field. As a matter of fact, I think, Mr.
23 Chairman, I can say that we want to make some modest
24 beginnings as early as possible in the field of
25 providing home nursing care. As we see in this the
26 type of approach that will supplement our hospital
27 programme, our medical care programme, our programme
28 for the aged, and in fact, almost every programme that
29 we can call to mind, I don't urge as a matter of
30 fact that this particular programme isn't one that



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1 will take priority in our minds, but the first thing
2 to us is the provision of a medical care programme in
3 the terms of the legislation that was passed last fall.

4 COMMISSIONER GIRARD: Mr. Minister,
5 I had a question that you partially answered just now,
6 and the question pertained to page iii of the Summary,
7 paragraph P, where it states that:

8 "It is the view of the Government
9 of Saskatchewan that we should strive
10 for a balanced programme of providing
11 health services".

12 And one of these services is home
13 care. My question was do you believe that the
14 implementation of the medical care plan will give
15 impetus to the need for the home care plans?

16 HON. MR. DAVIES: Yes, I think
17 it will, and I think that it will assist that programme.
18 I think it will assist our hospital programme. I
19 think it will introduce the kind of a concept that
20 perhaps obviates the idea of institutionalism or
21 institutionalization, if you like, and I personally,
22 I am not able to speak on this matter now with any
23 certainty, would wish to proceed on this type of
24 programme at as early a date as possible.

25 COMMISSIONER GIRARD: Mr. Minister,
26 since the nurses are the prime prerequisite for such a
27 programme, I understand that you have to have nurses
28 first, and homemakers also in large quantities. Do
29 you believe that you would have enough nurses,
30 graduate nurses, registered nurses, to implement

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1 this programme in the near future? By this, Mr.
2 Minister, I also meant keeping in mind that you will
3 need more nurses for the implementation of all the other
4 recommendations that you have here?

5 HON. MR. DAVIES: Well, Mr.
6 Chairman, this matter is now receiving the attention
7 of the Saskatchewan Registered Nurses' Association.
8 We have asked for their opinion on this special item.
9 Our projection is that we would need for this particular
10 service about one hundred and ten nurses in the Province,
11 one hundred and ten registered nurses, and, of course,
12 this might broaden, extend later on, but this would give
13 us a reasonably broad and a reasonably satisfactory
14 service. We think that this number can be provided with
15 not too much difficulty, and our training places are
16 adequate for the task.

17 COMMISSIONER GIRARD: In this
18 estimate of one hundred and ten additional registered
19 nurses for this service, Mr. Minister, with this did you
20 have in mind community-based home care services or
21 hospital-based home care services? You must have some
22 plan, since you have the amount of one hundred and ten
23 additional nurses needed?

24 HON. MR. DAVIES: We are thinking
25 of something that is community-based, with hospitals
26 involved, but I am afraid we do not have all of our
27 ideas worked out in this respect, but certainly we want
28 to involve a reasonably large area. As I recall
29 discussion on this, we are thinking about working out
30 fifteen miles from principal centres, and that this



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1 would give us a coverage of about eighty or eighty-five
2 per cent of the total population. We thought that this
3 would be a very good beginning, and probably in the
4 analysis a successful programme depends upon a
5 co-ordination of all the elements in the area that are
6 giving and receiving the services.

7 Certainly, I think the hospital
8 would be involved. Certainly, I think you would have
9 to have some involvement of the physician. We have,
10 as you know, thirteen health regions in the Province.
11 I think it would be more than desirable to have them
12 as a part of this idea, so that I suppose you could say
13 maybe it is very general, we hope to work these things
14 out together.

15 COMMISSIONER BALTZAN: Mr. Chairman,
16 I know the time is getting on, but may I take the
17 liberty on this occasion to pay tribute to the services
18 performed by the Department of Public Health in
19 Saskatchewan under all regimes. I may say I enjoyed
20 excellent co-operation in very many ways throughout the
21 years of my professional services in Saskatchewan.
22 There were differences, but always concessions on both
23 sides.

24 Mr. Minister, anything I may ask you
25 now is simply to help our understanding better, and
26 no other meaning is implied. Mr. Chairman, I trust
27 you will keep me in the righteousness of my path.

28 THE CHAIRMAN: Let your conscience
29 be your guide, Doctor.

30 COMMISSIONER BALTZAN: Mr. Minister,



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THE CHAIRMAN: Let your conscience
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1 page 1, paragraph 9, just the first portion:

2 "The Government of Saskatchewan
3 believes that every person in Canada
4 has a right to necessary health services."

5 My question is this: is it correct
6 to read that necessary health services is at least
7 equal to the right for all other institutions of life?

8 HON. MR. DAVIES: In terms of
9 food, clothing and shelter, and things of this kind --
10 I think in broad terms, yes.

11 COMMISSIONER BALTZAN: I believe
12 so. I assume that within the context of "right"
13 people in their right minds and who do not endanger
14 their neighbours will have the right to refuse to go
15 to a hospital, refuse an operation, refuse a blood
16 transfusion, refuse to take personal precautions, may
17 even refuse to drink fluoridated water, within the
18 terms and meaning of "right". This is not-----

19 THE CHAIRMAN: Are you asking the
20 Minister to answer the question?

21 COMMISSIONER BALTZAN: I am
22 assuming --- and I want to know if I am right?

23 HON. MR. DAVIES: Well, I would
24 think certainly we do not want to drag a person to a
25 hospital or a doctor's office to enforce treatment.
26 I think enough people do that now themselves, and per-
27 haps it may impose a kind of condition that is complain-
28 ed of in that respect rather than the other.

29 COMMISSIONER BALTZAN: I am trying
30 sir, to put the right on both sides.



page 1, paragraph 9, just the first portion.

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COMMISSIONER BATTAN: I am asking



1 On page 3, sir, the World Health
2 Organization's definition of health: It is at the
3 bottom of page, and I say, before I put my question,
4 that it is a good definition. It seems, however, to
5 focus on to and place the problem in the laps of the
6 framework of the present elaborate medical team group,
7 as it were. I think I shall read, for those who may
8 listen, the definition:

9 "Health is a state of complete
10 physical, mental and social well-being
11 and not merely the absence of disease
12 or infirmity."

13 I say again it seems to place this
14 and the responsibility in the area and framework of
15 our so-called and present day elaborate medical team
16 groups. My question is, are not other teams, or other
17 organizations, I say, even more involved especially in
18 the preventative aspects? Do I make myself clear?
19 As one reads this, it seems that all this falls upon
20 just taking the question of the health situation as a
21 medical problem, and by "medical" I mean in the widest
22 sense; but, there are other things.

23 HON. MR. DAVIES: I am not quite
24 sure what you mean.

25 COMMISSIONER BALTZAN: Shall I
26 explain: I refer to other areas: Eating too much, or
27 not eating enough, disabilities due to accidents --
28 road, factories, farms, homes and offices -- alcoholism,
29 drug addiction, delinquencies, etcetera, stresses and
30 strains due to over-work, worry and insecurities, which



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explain: I refer to other areas. Having too much, or not eating enough, disabilities due to accidents --

road, factories, farms, houses and offices -- accidents.

stresses due to over-work, worry and anxieties, which



1 tend to undermine health. In other words, there are
2 other agencies besides the medical team-work that is
3 concerned with the health of the people?

4 HON. MR. DAVIES: Yes, I think there
5 certainly are a large number of people interested in the
6 areas you are speaking about, Doctor.

7 COMMISSIONER BALTZAN: Sometimes,
8 can we say that these health problems result from the
9 failure on the part of other agencies or organizations
10 -- and I name, say, what happens as a result of abuses
11 or irregularities in our observing the traffic laws,
12 as a result of poor economics, poor social conditions,
13 and perhaps even low morale. I am trying to broaden
14 these contributory elements which come into this
15 question of the definition of health by the World Health
16 Organization. It is not just a medical problem in its
17 widest sense.

18 HON. MR. DAVIES: No. I think we
19 quite freely say we do not see it as only in that scope,
20 Doctor, and we think of all of the governments, all of
21 the agencies, all of the professions, all that have
22 anything to do with the amelioration of conditions caused
23 by any of the things you are thinking about are prime
24 matters for our consideration and have to be viewed as
25 such in the totality of this healthiness state we have
26 pictured in the brief, and I don't think I would have
27 any difference with you there at all, sir, that all of
28 these are extremely important to the scheme of total
29 health we are looking for, and which we think is desir-
30 able, and probably here again one of the tasks of



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28 any difference with you there at all, sir, that all of
29 these are extremely important to the scheme of total
30 health we are looking for, and which we think is desirable, and probably have seen one of the tasks of



1 government is to achieve a binding together of all the
2 elements that perform services, that render through
3 organizations some sort of service so that they will be
4 expressed best in the public interest. By this I don't
5 mean the task should be confined to government, but
6 should extend to the voluntary groups that give very
7 good service, and it should extent to every area, in a
8 word, that contributes to the state of health. We have
9 admitted we are not quite sure what it is; we would
10 like to know what it is, but we all know it is a desir-
11 able objective, and we think, with you, that it certainly
12 is part of what we are looking for.

13 COMMISSIONER BALTZAN: Thank you,
14 Mr. Commissioner. I emphasize this only because in
15 reading the definition one takes that very quick
16 assumption that it has to do with just medical team-work,
17 and you did also touch upon this very same thing on page
18 4, paragraph 13:

19 "For a variety of reasons, social,
20 cultural, economic or other, he seeks
21 no treatment and hence does not come
22 to the attention of the society."

23 It is within the same context even
24 if it does not read exactly like that. This is the
25 person to whom much of our effort in physical fitness
26 programmes is aimed now vis-a-vis the reasons --- social,
27 cultural, and economic --- and having touched on these
28 very key points, Mr. Minister, and all of these are
29 equally important, my questin is: Why isolate physical
30 fitness programmes alone when reading that?



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1 HON. MR. DAVIES: Well, we may have
2 perhaps in this paragraph been unintentionally misleading.
3 I don't think we are here envisaging only the physical
4 fitness programme that we read about concerned with new
5 ways of keeping fit --- muscle tone, gymnasia and the
6 like; we are not only thinking of that, but physical
7 fitness in the sense of perfect health. So, if this
8 phrase here makes you think of only one small programme,
9 I must apologize.

10 COMMISSIONER BALTZAN: Yes. In my
11 own way of reading it, one can perhaps assume that one
12 is made to feel better in order to suffer better the
13 evils of our society.

14 I have just a few short questions.
15 On page 6, paragraph 17:

16 " We believe that any enforced
17 programmes for fitness beyond school
18 age are unnecessary and undesirable,
19 except in certain emergencies, such as
20 those which occur in times of national
21 peril."

22 Please excuse my innocence or ignor-
23 ance but my question is: Are there any enforced programmes
24 outside of physical, dental and ocular examinations?

25 HON. MR. DAVIES: I can't think of
26 any, and I must say I think you have to relate that
27 sentence to the previous one where we say:

28 " We do not suggest that it follows
29 that the objective measurement of the
30 level of healthiness will lead to the



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HON. MR. DAVIES: I can't think of any, and I must say I think you have to relate that sentence to the previous one where we say:

"We do not suggest that it follows that the objective measurement of the level of healthiness will lead to the



1 type of regimentation which will assure
2 that everyone must perforce be dragooned
3 into fitness programmes."

4 We are suggesting here that we are
5 not looking to the sort of totalitarian situation where
6 people get good health because of enforced physical
7 jerks, as it were.

8 COMMISSIONER BALTZAN: But there is
9 a suggestion, although I think I understand you correctly
10 that you inform me that there is no enforced programme
11 under sixteen as yet except for physical, dental and
12 ocular examinations.

13 HON. MR. DAVIES: Dr. Roth points
14 out the only programmes that probably could even be
15 likened to this are programmes in the schools where there
16 may be some time devoted to physical training and that
17 kind of thing. What we were getting at here is that
18 the level of healthiness should not be thought of in
19 terms of something that is forced on the individual.
20 What we want to do is try and get the situation where
21 the individual does a desirable thing because he sees
22 them as necessary things.

23 COMMISSIONER BALTZAN: On page 9,
24 paragraph 25:

25 " Similarly we suggest that in
26 the main programmes designed to encourage
27 the maintenance of health and the pre-
28 vention of disease should be developed
29 in an organized way. Such developments
30 may come through official agencies of



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COMMISSIONER BAINMAN: On page 9,

"Similarly we suggest that in

the main programme designed to encourage
the maintenance of health and the pre-
vention of disease should be developed
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may come through official agencies of



1 governments or through voluntary
2 associations where a co-ordinated effort
3 can be made."

4 My emphasis is on "voluntary
5 associations." May I say we have already heard elsewhere,
6 where government provisions are made, the interests of
7 voluntary agencies fade and private contributions de-
8 crease. It is not my say-so; it is what I heard. In
9 that case, how can public participation be stimulated
10 if this statement is correct?

11 HON. MR. DAVIES: Well, I think we
12 have had in this province, Mr. Chairman and Dr. Baltzan,
13 a number of programmes of the type that are pictured in
14 this paragraph. At the same time I think it is true to
15 say we have had also an enormous involvment of voluntary
16 agencies and people who are desirous of assisting the
17 cause of good health in all sorts of different ways.
18 I am not going to enumerate the organizations, but I
19 think we can say simply that in our view the efforts of
20 voluntary agencies in Saskatchewan have not withered
21 away, but have probably been enhanced because of our
22 public programmes. It seems too that as people become
23 more aware you increase their activity within this type
24 of body. Of course, I am not suggesting here at all
25 that the whole matter of the co-ordination of programmes,
26 making the best use of voluntary bodies, is not touched
27 upon here. I think this is something we all have to
28 look at within the voluntary organizations we are
29 members of so as to make our effectiveness the best in
30 the terms we want it to be, but I think we don't see



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1 there is necessarily by any means a decline or a slacken-
2 ing of personal initiative on voluntary action simply
3 because the public through governments is now going into
4 medical care programmes of different kinds.

5 COMMISSIONER BALTZAN: In other
6 words, one may conclude from your remarks that your
7 experience has been different from other places and other
8 areas who made me quote here? You have not found that
9 to be the case?

10 HON. MR. DAVIES: I simply am not
11 familiar with the examples that have been quoted to you,
12 so it is hard for me to give an answer.

13 THE CHAIRMAN: The specific matter
14 -- and I think it was in a limited field, as Dr. Baltzan
15 will recall, was that the hospitalization programme
16 where government, both at the Federal and Provincial
17 level, were assuming the responsibility for hospital
18 payments was having the effect of drying up the donation
19 dollar, and it also had a serious effect on the material
20 available for clinical instruction of internes in the
21 hospitals. Those are the two areas in which we heard
22 that there might be an adverse effect from a so-called
23 compulsory programme of government involvement.

24 HON. MR. DAVIES: I could, comment
25 further, Mr. Chairman, but Dr. Roth has had, of course,
26 a great deal of experience since the beginning of our
27 hospital plan here, or shortly afterwards, and with your
28 permission I would ask him to comment on this side of
29 things.

30 DR. ROTH: Mr. Chairman, it is



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further, Mr. Chairman, but Dr. Roth has had, of course, a great deal of experience since the beginning of our hospital plan here, or shortly afterwards, and with your permission I would ask him to comment on this side of



1 difficult, I would think, in this province to comment on
2 the drying up of donations for capital purposes because
3 those of us who have been in Saskatchewan for some time
4 realize that the situation in this province is quite
5 different from what it is in other provinces. We have
6 had a long history in this province of capital costs of
7 hospitals being supported from tax resources. The whole
8 development of their union hospitals and the municipal
9 hospitals and, as a matter of fact, we only have three
10 kinds of hospitals in Saskatchewan: those operated
11 directly by the provincial government; those that are
12 the responsibility of the municipal governments, or
13 through unions of municipal governments; and those that
14 are operated by Sisters of the Roman Catholic Church.
15 We do not have a typical voluntary hospital as these
16 are known elsewhere. So, it is very difficult to
17 comment on this point as far as Saskatchewan experience
18 is concerned, although some few years ago we did carry
19 out a survey and found there had been no change in the
20 limited amount --- and it has always been a limited
21 amount --- of voluntary giving to hospitals. This has
22 not changed after the hospital plan had been in operation
23 for, at that time, about seven, eight or nine years;
24 I don't remember the exact date of the study.

25 On the question of clinical material,
26 again our experience may not be too relevant because
27 in this province we again have never had the development
28 of the typical public ward as these are known in the
29 larger cities. We have never had the development of
30 large-scale out-patient departments where free service



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1 is given to people or service, at least, for a very
2 minimal utilization charge. Even throughout the thirties
3 in this province, when things were fairly tough, these
4 out-patient departments did not develop. Individual
5 physicians in Saskatchewan continued to look after their
6 individual patients and provide service free of charge
7 if there was no money, or deferred the account until the
8 rains came.

9 Insofar as the hospital plan anti-
10 dated the development of the medical school and was in
11 operation some years before the University Hospital came
12 into operation, I think the people from the University
13 Medical College will probably be prepared to testify on
14 this more explicitly than I, but my understanding is
15 and I am in fairly close association with the arrange-
16 ments there, it is a very rare instance when patients
17 who are admitted to the University Hospital refuse to
18 permit their case to be used for medical teaching.
19 Those are very rare instances. My belief is that in
20 the other hospitals of the province there has not been
21 a tendency for patients to refuse to be used as suit-
22 able teaching material for internes in those hospitals
23 where medical students are not involved. I am sure one
24 of the members of your Commission has had much more
25 experience on this than I have and would be able to deal
26 with this aspect.

27 COMMISSIONER BALTZAN: I can support
28 you on the last statement. In seventeen years teaching
29 at St. Paul's Hospital I have had only two people de-
30 cline to appear and each one for a very good reason,



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1 because they just did not feel too well, not because
2 they did not like to come.

3 THE CHAIRMAN: On that note of
4 optimism we will now adjourn until 2.00 o'clock.

5
6 --- Luncheon adjournment

7
8 --- On resuming at 2.00 o'clock

9
10 THE CHAIRMAN: Ladies and gentlemen,
11 if you are ready we will come to order and proceed.
12 Doctor Baltzan.

13 COMMISSIONER BALTZAN: Yes. Mr.
14 Minister, I have only a few more little questions left.
15 Now, on page 24, paragraph 64:

16 "The training of personnel has local,
17 provincial and national interest."

18 My question is: Do you foresee a
19 university fee for learning basis or a public and high
20 school non-personnel costs in this training programme?

21 HON. MR. DAVIES: I beg your pardon?

22 COMMISSIONER BALTZAN: Will people
23 have to pay for it or will it be provided, at least, paid
24 in part?

25 HON. MR. DAVIES: I think, sir, that
26 we would expect to see in the training of personnel at
27 all levels in the whole programme a much heavier involv-
28 ment of public or government, if you will, voluntary
29 agencies. Perhaps a much heavier involvement in helping
30 to train people through bursaries, through all sorts of



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we would expect to see in the training of personnel at

agencies. Perhaps a much heavier involvement in helping

to train people through bureaus, through all sorts of



1 assistance. I do not think there will ever come the
2 day when the person himself does not have to make some
3 sort of contribution. However, I think our attitude is
4 this, that that contribution should not be so heavy as
5 to prohibit, exclude or discourage training of people
6 who want to receive that training.

7 COMMISSIONER BALTZAN: On the same
8 page, paragraph 66, you refer to the development of
9 institutes for various projects or areas. Do you count
10 on these institutes the same autonomous basis as, say,
11 provincial universities?

12 HON. MR. DAVIES: Well, if as we
13 anticipate as the years go by we are able to secure
14 enough experience in each of the areas to have the region-
15 al set-up that I think I spoke about this morning, it
16 seems to me that this could become a part of that, and
17 so they would get something that is highly co-ordinated
18 but at the same time highly decentralized, if I may say
19 so, in trying to convey something that may appear to be
20 at first blush a little contradictory, to try to get
21 the proper type of community involvement, and at the same
22 time, the maximum of co-ordination as between these areas.
23 Now, I do not pretend to be, in this respect, at least,
24 an expert and it may be that Dr. Roth or some of my
25 associates here this afternoon would care to add to what
26 I have to say. That, at least, is a superficial and
27 general answer to your question.

28 DR. ROTH: I would like to merely
29 comment further that what is envisaged here, as I take
30 it, is that certain types of institutes are regional



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28 DR. ROTH: I would like to merely
29 comment further that what is envisaged here, as I take
30 it, is that certain types of institutes are regional.



1 in this sense, I think, refers more to inter-provincial
2 areas as we think of it, the Prairie region or the
3 Maritime region or the Atlantic Provinces. That has
4 certain types of highly specialized care and complex
5 services to become elaborated on. It might be desirable
6 and it is desirable in our view to provide for regional
7 institutes where this type of work can be done. The
8 Montreal Neurological Institute being a pattern that we
9 suggest, not necessarily that it be followed slavishly,
10 but at least it forms the kind of pattern where this
11 highly specialized work might well be done. We would
12 envisage these financed jointly by either Federal-
13 provincial or inter-provincial financing. I would agree
14 that they should have a very large measure of autonomy.
15 Whether they have the kind of autonomy of a university
16 or not, I do not know that are thinking has gone this
17 far.

18 COMMISSIONER BALTZAN: It may be
19 self-contained and the work will be as they see fit to
20 carry on. For instance, in the Institute of Neurology
21 or Pathology they will be autonomous?

22 DR. ROTH: I would think so, yes.

23 COMMISSIONER BALTZAN: Mr. Minister,
24 my final question, on page 20, paragraph 55, you say:

25 "It is our submission, therefore,
26 by the nature of the problems involved, the
27 prime responsibility of government at all
28 levels is to plan comprehensively for the
29 development of appropriate health services."

30 I take it that planning is not the



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highly specialized work might well be done. We would
envisage these financed jointly by either Federal-
provincial or inter-provincial financing. I would agree
that they should have a very large measure of autonomy.
Whether they have the kind of autonomy of a university
or not, I do not know that one thinking has gone this
far.

COMMISSIONER BARTZMAN: It may be
self-contained and the work will be as they see fit to
carry on. For instance, in the Institute of Neurology
or Pathology they will be autonomous?

DR. ROTH: I would think so, yes.
COMMISSIONER BARTZMAN: Mr. Minister,
my final question, on page 20, paragraph 25, you say:

"it is our submission, therefore,
by the nature of the problems involved, the
prime responsibility of government at all
levels is to plan comprehensively for the
development of appropriate health services."

I take it that planning is not the



1 same in peace-time as it is in times of a national
2 emergency? I mean, there is not the same sense of urgen-
3 cy, is there? I agree with the question of planning and
4 the responsibility but there is a difference in the
5 senses of urgency in peace-time or peace measures against
6 catastrophic things or national emergencies?

7 HON. MR. DAVIES: I think, Dr.
8 Baltzan, that this much is true, that in a war-time
9 period there are very apt to be short-cuts that many ignore
10 the community, they may try to do in the quickest way
11 what is desired. However, I do not think at the same
12 time that there are any situations in peace-time that do
13 not require the urgent solution. In other words, I do
14 not think we can long delay attempts at solutions so
15 these problems are enhanced because they take place in
16 peace-time. I think the sort of co-ordinated attack on
17 the problem of disease to attain good health in the terms
18 we have tried to picture it in this brief are still
19 indicated in this kind of approach. Certainly in doing
20 this you want to get the greatest possible participation
21 of all the elements that are taking part, the receiving
22 services, agencies of all descriptions that have an
23 interest so as not to ignore them and take away this very
24 priceless component in bringing these services to the
25 people that are concerned. I suppose, though, in
26 answering more shortly that there is generally, or has
27 been generally, differences in the approach in handling
28 almost anything during the war-time period and a peace-
29 time period because of the desperate need and the
30 particular urgencies that are required.



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1 COMMISSIONER BALTZAN: Finally, Mr.

2 Minister, the reason why I posed this question and phrased
3 it that way is because I see that action has been taken
4 on an interim report of the Advisory Planning Committee
5 rather than, say, completion of the report.

6 HON. MR. DAVIES: Yes, ~~that~~ is true,
7 sir. That action has been taken through legislation to
8 work into effect a medical care plan and recommendations
9 are based, to a considerable degree, on this interim
10 report. I want to point out further that this is by no
11 means the first of such reports or the sole extent of
12 knowledge on this problem in this province. I would point
13 out that in 1951 we had a report of a health survey
14 committee that reported on, not the same principles, but
15 on parallel lines. I want to point out that it was in,
16 if I might refer to it here without damaging any
17 sensibilities, the election campaign of 1960, that this
18 whole question of a public medical care plan was very
19 widely and some times hotly discussed. Between that time
20 and this a fair measure of time has elapsed. We have
21 had the advice of all of the briefs that have been
22 submitted to the Advisory Committee. We believe that
23 enough in the way of information is available to form
24 the framework of a plan, and moreover, we say we leave
25 to a commission the job of doing the day to day job, all
26 the negotiations with persons that give the service so
27 that in this background with the background of experience
28 that has developed indeed since 1947, with the advent
29 of the hospital plan, we do not see that there has been
30 any really desperate haste, any unseemly haste at all.



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1 COMMISSIONER BALTZAN: In my
2 conclusion I must tell you you have been very patient
3 indeed. I am very much impressed by the breadth and
4 depth of the total concepts. Any more information we
5 can get on the practical applications of many propositions
6 I am sure will help us immensely and I thank you.

7 COMMISSIONER STRACHAN: Mr. Minister,
8 one or two general questions and then I shall turn to
9 those more specifically pertaining to the mental angle.
10 The \$12.00 or \$24.00 fee has been referred to as being
11 compulsory; are there some people in this province who
12 are unable to pay that fee, individuals who are generally
13 classed as indigents and how do you determine that?

14 HON. MR. DAVIES: There are, of
15 course, some groups as you suggested that are indigent
16 and cannot of themselves through their own finances pay
17 this fee. These, we suggest, would be paid in the same
18 manner as it is now accomplished with our hospital
19 payments, the per capita payment for the hospital plan
20 and it is undertaken under the responsibility of each
21 municipality where people are on social aid and are not
22 able to look after themselves. I believe there are other
23 sections of the Saskatchewan population where arrangements
24 are made as between the Federal Government and ourselves
25 for the paying of the per capita tax so far as hospitali-
26 zation is concerned.

27 Now, we have not as yet any such
28 arrangement that will follow that medical care, but I
29 think it is anticipated that these arrangements are
30 desirable and it is probable that such arrangements will



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1 be made with the Medical Care Commission to cover groups
2 such as, for instance, our Indian population.

3 COMMISSIONER STRACHAN: Will your
4 medical care plan encompass full health and educational
5 care for such groups as the retarded, the crippled, the
6 cerebral palsy, the muscular distrophy group?

7 HON. MR. DAVIES: Yes, I think so.

8 COMMISSIONER STRACHAN: On page 34,
9 you mention the Hospital Renovation Grant. What is that
10 figure?

11 HON. MR. DAVIES: Which particular
12 paragraph were you referring to? 93?

13 COMMISSIONER STRACHAN: The last
14 sentence in 93.

15 DR. ROTH: This is a grant which is
16 presently available under the National Hospital Construc-
17 tion Grant, it is part of the grant formula where the
18 renovation project is carried out. The nominal project
19 will be considered as \$3,000.00, if there is any renova-
20 tion project \$3,000.00 or in excess of this providing
21 the provincial government makes a grant to the hospital
22 of one-third, the Federal Government will match this by
23 one-third, and the other one-third is left for the
24 hospital to pay. This has been a national health grant
25 and has been in operation since 1958, I think.

26 THE CHAIRMAN: And you regard it as
27 satisfactory?

28 DR. ROTH: Yes, sir.

29 COMMISSIONER STRACHAN: In your brief
30 you have mentioned the critical shortage of dentists in



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DR. ROTH: Yes, sir.

COMMISSIONER STRACHAN: In your brief

you have mentioned the critical shortage of dentists in



1 this province, what is the government or has the govern-
2 ment done to relieve this extreme shortage?

3 HON. MR. DAVIES: We have some
4 grant basis or bases here, and I think perhaps Dr. Roth
5 could answer this.

6 DR. ROTH: We have made available
7 for the last several years grants for students in their
8 final year of dentistry in the anticipation that they
9 would have some financial difficulties, and in return for
10 a grant of \$1,000.00 to assist them in their final year
11 of education they would undertake to return to Saskatche-
12 wan and practice in one of the areas outside of the
13 major cities in Saskatchewan. The shortage here, of
14 course, as in most other provinces, is relative, it is
15 worse in the smaller communities than it is in the larger
16 cities.

17 THE CHAIRMAN: To return for how long
18 a period?

19 DR. ROTH: Year for year. That has
20 been a bit unhappy in the fact that not very many students
21 are coming forward for this type of assistance although
22 our experience is that on the basis of students per
23 population that Saskatchewan has a fair ratio of students
24 from Saskatchewan entering dental schools; to population
25 it appears favourable with the rest of Canada. What
26 the reason for the failing is we have not been able to
27 find out, but they are not coming forward for this
28 assistance. Perhaps they do not need it. This is one
29 effort we have made.

30 We have also attempted to stimulate



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29 We have also attempted to stimulate



1 the development of better dental hygiene particularly to
2 develop this through our regional health programmes.
3 Over the years we have trained a considerable number of
4 dental hygienists at the school in Toronto, the two year
5 course. They go through there and come back to
6 Saskatchewan. This programme has met with extreme
7 difficulty and we have virtually abandoned this training
8 programme because we have found it impossible to keep
9 these girls working in the rural setting that pertains
10 in rural Saskatchewan. This has been a very real matter
11 of concern as to how we might bring to the people,
12 particularly to the children, a co-ordinated and
13 comprehensive and intensive programme of dental hygiene
14 education combined with the work of these hygienists in
15 the application of topical fluoride. We must confess
16 that this is one programme that we feel we are unhappy
17 about and that we have failed in, frankly.

18 THE CHAIRMAN: Have you a government
19 policy on fluoridation?

20 DR. ROTH: Yes, sir. The Minister
21 of Health, I don't know if the present one has, but
22 previous Ministers of Health have stated quite positively
23 that they are definitely in favour of it. That is,
24 communal fluoridation. We have urged the development of
25 a topical fluoridation, and in addition to this, we are
26 now through our Public Health organizations making
27 fluoride tablets available to children at no expense to
28 them, that is, that these are provided free of charge
29 in areas where communal fluoridation of water is not
30 possible, and where after a careful investigation the



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in areas where communal fluoridation of water is not
possible, and where after a careful investigation the



1 fluoride contained is not already high. We don't just
2 broadcast it wholesale.

3 COMMISSIONER BALTZAN: Have you met
4 with any opposition to fluoridation? Some areas have,
5 and there has been a referendum.

6 DR. ROTH: Yes.

7 COMMISSIONER BALTZAN: Has there been
8 any in Saskatchewan?

9 DR. ROTH: Yes, there have been two
10 votes in Regina, for example, and North Battleford, and
11 the vote for fluoridation was defeated. We have quite
12 a number of communities which have fluoridation now,
13 Saskatoon, Prince Albert, Assiniboine, quite a large
14 number. They have communal fluoridation under way but --

15 COMMISSIONER STRACHAN: Well, Mr.
16 Minister, shall we get back to the original subject
17 mentioned, that of bursaries?

18 HON. MR. DAVIES: Yes, sir.

19 COMMISSIONER STRACHAN: Could you
20 give us the figures of the amount of money you have loaned
21 on these persons, and the number of refusals you have made,
22 and the reasons for same, and you have mentioned that
23 possibly the need was not there. Might need not be there
24 in the early years of their dental education? It would
25 seem to me that when a student is about to graduate, he
26 could procure the money almost anywhere, but I think the
27 need for money is in the early years of a dental course?

28 HON. MR. DAVIES: I think on the
29 first question we will make a note of your question of
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18 number. They have communal fluoridation under very low
19 COMMISSIONER SAMPSON: Well, the
20 Minister, shall we get back to the original subject
21 mentioned, that of pureness?
22
23 HON. MR. DAVIES: Yes, sir.
24
25 COMMISSIONER SAMPSON: Would you
26 give us the figures of the amount of money you have spent
27 on these persons, and the number of persons you have had
28 and the reasons for same, and you have mentioned that
29 possibly the need was not there. Might need not be there
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31 seem to me that when a student is about to graduate, he
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33 need for money is in the early years of a dental course.
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35 HON. MR. DAVIES: I think in the
36 first question we will make a note of your question of
37 figures and try to supply that for you, if we don't have



1 it here.

2 On the other question, I suppose Dr.
3 Roth is referring to those people who were actually
4 concerned in training. There may be others who would
5 have taken training if they could have had more adequate
6 bursaries, and I think we would acknowledge probably
7 there could be an improvement in respect of assistance
8 for this type of training.

9 COMMISSIONER STRACHAN: What is the
10 basis on which these bursaries are extended? I am
11 thinking of interest charges and repayment?

12 HON. MR. DAVIES: Here again, I think
13 Dr. Roth will supply the specifics.

14 DR. ROTH: There are no interest
15 charges. These are an outright grant made, and the
16 applicant agrees, as I say, to return to fulfill a term
17 of service in an area in Saskatchewan outside of the
18 major cities, and that if he fails to do this, then he
19 is obligated to return, if he fails to establish a
20 practice at all, then he, of course, is obligated to
21 return all the money he got. If, however, he fulfills
22 half his commitment, he returns half of it, and three-
23 quarters of it, he returns one-quarter of it.

24 COMMISSIONER McCUTCHEON: Do you help
25 him to establish his practice in these outlying areas?

26 DR. ROTH: No, sir. We have not
27 recently although we attempted this at one time. Again,
28 through the generosity of the National Health Grants we
29 obtained some of the equipment, and this was placed in
30 some of the rural areas where there was the greatest



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1 apparent need for dentists, and in some instances the
2 local communities established an office. In one or two
3 situations offices were established in new hospitals
4 that were being constructed. These have not succeeded
5 in keeping dentists in these areas either.

6 COMMISSIONER STRACHAN: Recognizing
7 that there are hospitals, as you have just stated, in
8 areas where dentists would not locate, have you the
9 physical facilities in any of your hospitals which would
10 accommodate a dentist, perhaps on a part-time basis,
11 perhaps going from one hospital to the other, and
12 supplying service to that community?

13 DR. ROTH: I would think yes, sir,
14 there are a number of hospitals that could accommodate
15 a dentist in an out-patient department or in special
16 office facilities, and as I indicated there have been
17 some hospitals that have set up this type of fixed
18 installation for the dentist to come in.

19 COMMISSIONER STRACHAN: Yes, that is
20 what I mean. They have set them up?

21 DR. ROTH: Yes.

22 COMMISSIONER STRACHAN: How many in
23 the Province are there where there are physical facilities
24 ready for a dentist to go to work?

25 DR. ROTH: I couldn't say off hand.

26 COMMISSIONER STRACHAN: Would you
27 care to give it?

28 DR. ROTH: I will try to find out for
29 you. This envisages, I take it, by this you mean space
30 and facilities which would permit essentially a physician



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1 to operate -----

2 COMMISSIONER STRACHAN: Not a
3 physician, a dentist.

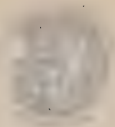
4 DR. ROTH: I am sorry, a dentist to
5 operate a private practice. I mean, there are a number
6 of our hospitals that have facilities in which dental
7 work can be done in the hospital, and in fact, a fair
8 amount of admissions to the hospital are for dental
9 purposes in this Province, but I take it that what you
10 mean is a facility in which a dentist could in effect carry
11 on the practice of dentistry?

12 COMMISSIONER STRACHAN: I mean are
13 there physical facilities there for him to step in and
14 carry on a dental practice?

15 DR. ROTH: Well, this would take an
16 examination of the hospitals, but we certainly could get
17 this, because this involves space for waiting rooms,
18 space for secretaries, and so on.

19 COMMISSIONER STRACHAN: In this
20 connection, recognizing the fact that many of the groups
21 that I formerly referred to, retarded, crippled, cerebral
22 palsied, can't receive dental attention in private offices,
23 have you any accommodation with any of your hospitals
24 where these children, or individuals, can be treated
25 of necessity many times under a general anaesthetic by
26 a dentist in the hospital, and coupled with that, I will
27 ask the question, have dentists the right of admission
28 and discharge in Saskatchewan hospitals?

29 DR. ROTH: I think the answer dealing
30 with your question in two parts as you asked it, is that



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Will your question in two parts as you asked it, is that



1 there are no hospitals that I know of in Saskatchewan
2 that have special facilities for the treatment of this
3 kind of case, that is, there are no organized programmes
4 as such for the treatment of them, and no special
5 facilities have been set up for this, although as I
6 indicated earlier, that patients may be admitted to
7 hospital for dental work, and this is recognized by the
8 Saskatchewan Hospital Insurance Plan, and the costs of
9 hospitalization in that instance is a responsibility of
10 the Plan, and not the responsibility of the patient.

11 Your second part of your question,
12 do dentists have the right to admit to hospitals? They
13 do not have the right to admit to hospitals on their
14 own account. They must admit their patients through a
15 medical practitioner, and although there is one and
16 perhaps two hospitals that have an organized dental
17 staff as such within the province ----

18 COMMISSIONER STRACHAN: Following
19 up part of that question, we have been assured that these
20 groups that I have mentioned, I don't think I have to
21 repeat them again, will receive full health and education-
22 al care. Is it anticipated that they will receive the
23 dental attention so essential to them, and where it is
24 impossible to receive it in any other place, in the
25 hospital?

26 HON. MR. DAVIES: I think the answer
27 to this question, Dr. Strachan, is that we haven't any-
28 thing of this kind in operation at the moment. Nothing
29 is envisaged at the moment in the medical care plan,
30 but it certainly is one of the things that we could



that have special facilities for the treatment of this kind of case, that is, there are no organized programmes

facilities have been set up for this, although as I indicated earlier, that patients may be admitted to hospital for dental work, and this is recognised by the Saskatchewan Hospital Insurance Plan, and the costs of hospitalization in that instance is a responsibility of the Plan, and not the responsibility of the patient.

Your second part of your question.

do dentists have the right to admit to hospitals? They do not have the right to admit to hospitals on their own account. They must admit their patients through a medical practitioner, and although there is one and perhaps two hospitals that have an organized dental

staff as such within the province ---

COMMISSIONER STRACHAN: Following

up part of that question, we have been assured that these groups that I have mentioned, I don't think I have to repeat them again, will receive full health and education al care. Is it anticipated that they will receive the dental attention so essential to them, and where it is impossible to receive it in any other place, in the hospitals?

HON. MR. DAVIES: I think the answer

to this question, Dr. Strachan, is that we haven't said anything of this kind in operation at the moment. Nothing is envisaged at the moment in the medical care system.



1 branch into after the first step has been established,
2 but this is not envisaged as part of the first step that
3 we have in mind. I would think it would be one of the
4 more logical steps that would be indicated in the future.

5 COMMISSIONER STRACHAN: I would hope
6 so, sir, because we recognize that these are helpless
7 individuals, and unless we do something for them nothing
8 is going to be done.

9 In the brief which we will receive
10 from the Dental Association of this Province, they will
11 be recommending the establishment of a dental school.
12 Is this in the Government's plans in the foreseeable
13 future, may I ask?

14 HON. MR. DAVIES: We have no
15 immediate plans for the establishment of a dental school,
16 sir. We would like to be in a position to do so, but
17 I don't need to tell you that this is a matter of some
18 fairly significant cost. A dentist in Moose Jaw the
19 other day was telling me about the cost of dental
20 colleges, and I know they reach very large proportions
21 indeed. I don't think this is excluded in our plans,
22 but we have no immediate plans for the construction of
23 a dental college in Saskatchewan.

24 COMMISSIONER STRACHAN: I am sure
25 one of my fellow Commissioners will be going into more
26 detail on this question, but we, like common people,
27 generally feel that hospital administration is expensive
28 administration. What is your estimate of the cost of
29 conducting the medical care plan? What percentage of
30 the dollar will go directly to medical services only?



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administration. What is your estimate of the cost of

conducting the medical care plans? What percentage of

the dollar will go directly to medical services only?



1 Have you any idea?

2 HON. MR. DAVIES: You are thinking,
3 sir, of the administrative costs?

4 COMMISSIONER STRACHAN: Yes.

5 HON. MR. DAVIES: Well, our feeling
6 now is that five per cent may look like a reasonable
7 figure. I think hospitalization is 4.5. The administra-
8 tion costs now of hospitalization is somewhat less than
9 four per cent, so we are thinking something about five
10 per cent handling for dental care. Now, there may be
11 other costs, sir, but I think you probably had in mind
12 chiefly the question of administration.

13 COMMISSIONER BALTZAN: Mr. Minister,
14 does that refer to the Department's cost of administra-
15 tion, or does that include also the administration costs
16 of each hospital, the personnel involved in administer-
17 ing?

18 HON. MR. DAVIES: No, there are
19 some other costs that are involved that are not shown
20 in that figure. The figure that we show is really not
21 so far as we are concerned, but there are also the costs
22 of administration for each hospital. Now, we don't
23 attempt to show these charges. We talk about handling
24 provincial plans in terms of our responsibilities.

25 COMMISSIONER BALTZAN: Do you pay
26 for both?

27 HON. MR. DAVIES: We pay for both.

28 THE CHAIRMAN: Well, they are part
29 of the operation charge for the hospital for which the
30 Federal Government makes a contribution as well?



1 HON. MR. DAVIES: Quite right, sir.

2 COMMISSIONER VAN WART: For infor-
3 mation, we heard quite a lot in one of the provinces
4 about the term semi-indigent, which I might define,
5 I think they defined it as excluding the indigent and
6 excluding those who could pay. That is, it is the group
7 who could pay part of the premium, and the rest of it,
8 of course, had to be paid by the State, or someone,
9 and on analysis we found that that took in about twenty
10 per cent of the population were in that semi-indigent
11 group. There was a survey made in this province by an
12 economist. How does your hospital plan deal with that
13 group? Where they cannot pay the full premium, but can
14 pay part. How do you deal with those?

15 HON. MR. DAVIES: I shall attempt to
16 answer part of that, and Dr. Matthews perhaps will
17 amplify what I shall say here. I haven't heard the
18 term semi-indigent in our terminology. We certainly
19 use the term indigent. Of course, we do pay now for
20 those persons who are in receipt of the supplementary
21 allowance. Then there is the section that I made some
22 reference to a little while ago when we were talking
23 about this subject, the persons that are on social aid,
24 or near social aid, and here the community is expected
25 to look after this obligation and pay the hospitalization
26 per capita tax for these people. Now, I don't think
27 that we have had too great difficulty with this process.
28 We do have a pretty good percentage of payments by those
29 that are concerned. Now, Dr. Matthews may care to add
30 to this, and pinpoint it just a bit more.



1 DR. MATTHEWS: Well, generally
2 speaking it is a municipal responsibility to determine
3 those people who are indigents, other than those re-
4 ceiving categorical assistance, and the municipality
5 usually assumes the liability for payment of their
6 premium. Under the Municipalities Act in this Province,
7 they may be responsible for the cost of care of people
8 who are medically indigent. Therefore, the municipality
9 pays the premium for these people generally.

10 COMMISSIONER VAN WART: It is not
11 that group I mean. It is the group between those who
12 can pay and the indigent in your various groups. For
13 example, temporary unemployment, long illness, or a
14 widow. Where they can pay part of it, but they do not
15 qualify as an indigent. How do they pay their premium?

16 DR. MATTHEWS: The municipalities
17 in many cases do pay the premium for people of this
18 nature, and the premium has been kept at a fairly low
19 level in order to make it possible for a high proportion
20 of the population to be able to pay the premium.

21 THE CHAIRMAN: That is the \$48.00
22 premium?

23 DR. MATTHEWS: Yes.

24 COMMISSIONER VAN WART: It came out
25 that about twenty per cent of the population in this
26 province qualify under that group, which is a large
27 segment ---

28 THE CHAIRMAN: When you say this,
29 you are talking about the province to which you are
30 referring, and not Saskatchewan.



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DR. MATTHEWS: What is the percentage

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COMMUNIST VAN WART: It seems only

that about twenty per cent of the population in this province qualify under that group, which is a large segment ---

DR. MATTHEWS: When you say this



1 COMMISSIONER VAN WART: Not
2 Saskatchewan. And as I understand you the municipality
3 steps in and pays the difference?

4 DR. MATTHEWS: Yes, sir.

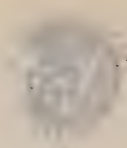
5 COMMISSIONER VAN WART: Do you
6 visualize the same thing under your medical service?
7 Does the municipality have a means test, or how do they
8 determine what amount they should pay for these people?

9 HON. MR. DAVIES: This I suppose
10 would come under the heading of the Department of Social
11 Welfare. They do have their means tests or needs test,
12 their means of discovering whether a person needs the
13 help or not, and we, of course, as Dr. Matthews has said,
14 are the ones who have to determine this initially.
15 I don't think it depends what indices you use, I suppose.
16 You talk about that in-between section of people who
17 are not on social aid, but might be near to it, at least,
18 sometimes during the year?

19 COMMISSIONER VAN WART: Yes, sir.

20 HON. MR. DAVIES: I think our best
21 answer is one I just briefly touched upon, where this is
22 the case and there is a considerable proportion of the
23 people begin to show up as non-payers, and when you
24 encounter this kind of a sign, then you can look to add
25 something else. Now, on the whole, our level of
26 collections has indicated that the present means are
27 reasonably satisfactory.

28 We don't suggest they may be ideal,
29 but they have been reasonably satisfactory and, of
30 course, the sum of \$48.00 is a charge for families, and



COMMISSIONER VAN WART: Not

And as I understand you the municipality

DR. MATTHEWS: Yes, sir.

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the sum of \$12.00 is a charge for families, and



1 \$24.00 for single persons.

2 COMMISSIONER FIRESTONE: Mr. Chairman:
3 Mr. Minister, you have been very helpful to the
4 Commission in setting out in your brief some of the basic
5 principles that guide you in developing a universal
6 medical care programme for the Province of Saskatchewan,
7 and you have submitted to us a number of general reasons
8 in support of your proposal. Would it be in order if I
9 question you on these principles and the general reasons
10 behind them?

11 HON. MR. DAVIES: Well, I certainly
12 would try to answer you, sir.

13 COMMISSIONER FIRESTONE: Thank you,
14 Mr. Minister. First, to deal with the area that we are
15 particularly concerned with, in the submission of the
16 Advisory Planning Committee on Medical Care, its interim
17 report, in Table 2 on page 22 the suggestion is made
18 that about 610,000 people in the Province of Saskatchewan
19 are covered by various medical care programmes, both
20 private and public, and on page 21 the point is made that
21 these various programmes cover about sixty-seven per
22 cent of the population of Saskatchewan. This suggests
23 that there are over 300,000 people in the Province of
24 Saskatchewan not covered by any programme, either private
25 or public. What we would like to know is, who are these
26 over 300,000 people who at the moment have no coverage
27 whatsoever for medical care?

28 HON. MR. DAVIES: Well, again, I will
29 try and answer generally and ask to be amplified by my
30 associates. I would say, first of all, that these are



1 the persons who have not taken out membership in any of
2 the private medical care plans, or are not covered by
3 some government assistance. In a word, these are the
4 people who, in any way, shape or form are now paying
5 their medical costs through other than a private group,
6 or whatever plans or public assistance. I don't know if
7 that is the correct answer you are looking for. It may
8 be you would like something slightly more definitive.
9 If so, I would be pleased to try.

10 COMMISSIONER FIRESTONE: Perhaps I
11 can be helpful by inquiring whether you would think in
12 this group there would be many people who are generally
13 described as medically indigent --- the sort of group
14 that my fellow Commissioner has been referring to a few
15 moments ago?

16 HON. MR. DAVIES: I think there will
17 be in this group undoubtedly a number of people, perhaps
18 a substantial number of people, who are, if not in the
19 indigent class as we might construe the word technically,
20 at least in a class that would find it rather difficult
21 to pay. On the other hand, there will also be in this
22 number of persons, I conceive, persons who might be able
23 to pay but still have not entered any of these other
24 arrangements. But, undoubtedly, I think there would be
25 quite a considerable number of persons who are either
26 indigent in the specific sense of the word or who are
27 near to it or whose income is, well, in the lower income
28 brackets. Also, these aged group, I am reminded by
29 Dr. Roth, will have to be considered here.

30 COMMISSIONER FIRESTONE: I take it



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Dr. Roth, will have to be considered here.



1 the purpose of introducing an universal and comprehensive
2 medical care programme for the Province of Saskatchewan
3 is that you had in mind first to cover people who are
4 not covered, and secondly, to cover people who are in-
5 adequately covered, and thirdly, to pay, either in part
6 or in full, for those who cannot pay for the services
7 themselves?

8 HON. MR. DAVIES: Certainly, the plan
9 envisages the payment for those persons who are not able
10 to pay for themselves.

11 COMMISSIONER FIRESTONE: I turn now
12 to paragraph C of your Summary, sir, in which you state
13 that one of the objectives of your plan is to organize,
14 plan and finance basic health services as public services:
15 Could you, Mr. Minister, or any or your associates,
16 define for the Commission what you mean by "basic health
17 services"?

18 HON. MR. DAVIES: Well, I think we
19 conceive of basic health services in the terms that I
20 tried to describe, perhaps roughly, this morning; that
21 is, services that are sufficiently adequate for the
22 population in terms of health services. Of course, this
23 embraces the whole gamut of those things that have to
24 be thought of in terms of healthiness, as the brief terms
25 it.

26 COMMISSIONER FIRESTONE: Would you
27 visualize under your scheme that persons could obtain
28 from their physicians supplementary health services and
29 pay for those supplementary health services out of their
30 own pockets?



or in full, for those who cannot pay for the services themselves?

HON. MR. DAVIES: Certainly, the plan envisaged the payment for those persons who are not able to pay for themselves.

COMMISSIONER FIFTHTON: I want now to paragraph C of your Summary, etc., in which you state that one of the objectives of your plan is to organize plan and finance basic health services as public services. Could you, Mr. Minister, or any of your associates, define for the Commission what you mean by "basic health services"?

HON. MR. DAVIES: Well, I think we conceive of basic health services in the terms that I have just mentioned. I think it is, services that are essentially adequate for the population in terms of health services. Of course, this emphasizes the whole gamut of those things that have to be thought of in terms of healthiness, as the word "basic" implies.

COMMISSIONER FIFTHTON: Would you visualize under your scheme that persons could obtain pay for those supplementary health services out of their



1 HON. MR. DAVIES: You mean there may
2 be services over and above the services rendered under
3 the plan that could be secured by an extra payment?

4 COMMISSIONER FIRESTONE: Yes.

5 HON. MR. DAVIES: I must say I hadn't
6 thought of this type of arrangement, but I don't think
7 it is excluded. There may be some kinds of treatment
8 that could be separate from the plan itself, but I must
9 say that, just thinking very rapidly, it is hard to
10 discern a very wide area.

11 COMMISSIONER FIRESTONE: Would, for
12 example, your plan encourage people over forty to go to
13 their physician regularly for a medical check-up, and
14 children under sixteen be brought to a physician regularly
15 for a medical check-up?

16 HON. MR. DAVIES: I would think, sir,
17 that on the whole this is what the plan that we envisage
18 would encourage, and I think in so doing perhaps detect
19 the early ailment, the early illness, or whatever, so
20 that curative measures can be applied.

21 COMMISSIONER FIRESTONE: In other words,
22 your definition of "basic services" would include numerous
23 visits for preventive medical purposes?

24 HON. MR. DAVIES: I think in this
25 aspect, that the answer would be in the affirmative.

26 THE CHAIRMAN: The Act says, "a
27 routine physical examination": 26 sub-section 8 (11) .

28 HON. MR. DAVIES: This, sir, I should
29 explain, my colleagues advise me, does not limit the
30 examination to "a" -- "one". It says "a routine physical



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aspect, that the answer would be in the affirmative.

THE CHAIRMAN: The A.C. says, "a

routine physical examination: 15 and-section 6 (a)."

HON. MR. DAVIES: This, sir, I should

explain, my colleagues advise me, does not limit the



1 examination", and this may be a series over a period.

2 COMMISSIONER McCUTCHEON: But it is
3 only an examination in accordance with the terms and
4 conditions specified by the Commission? I think Dr.
5 Firestone would be interested in knowing those terms
6 and conditions.

7 HON. MR. DAVIES: Would you like me
8 to answer that question?

9 THE CHAIRMAN: Yes.

10 HON. MR. DAVIES: These are the terms
11 and conditions that would be formulated by the Medical
12 Care Commission who, of course, are empowered and
13 authorized to make the necessary arrangements for those
14 services, and quite naturally will have to delineate
15 those services in regulations or in some appropriate
16 manual.

17 COMMISSIONER FIRESTONE: Mr. Minister,
18 what would be paid to physicians rendering the service --
19 one hundred per cent of the schedule of fees, or eighty-
20 five per cent; what would it be?

21 HON. MR. DAVIES: This is something
22 I cannot give you a definite answer on for the reason
23 that, again, it is for the Medical Care Commission to work
24 out these arrangements with those who render the service.
25 I think that there may have been a recommendation on this
26 by the Thompson Committee --- apparently not. As you
27 know, in some of the existing plans they speak of payment
28 on the basis of eighty or eighty-five per cent of the
29 schedule of fees, but this is not something that we will
30 work out. This is something that the Commission will work



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HON. MR. DAVIES: Would you like me

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1 out with those who render the service.

2 COMMISSIONER FIRESTONE: Mr. Minister,
3 this interim report pointed out that this subject of
4 fee payments is a very delicate one, and left it to the
5 good judgment of the Commission to be negotiated with
6 the medical profession. I can very well understand why.
7 May I ask you a question of principle: Let us assume,
8 for discussion's sake, that in this an understanding is
9 reached between the medical profession and the
10 Commission that eighty-five per cent would be the required
11 amount: Would the physician under your plan be permitted
12 to charge the other fifteen per cent to the patient?

13 HON. MR. DAVIES: As a matter of
14 principle, excluding -- I am trying to think of the powers
15 of the Commission, but I think it is in accord with the
16 answer I will give: As a matter of principle, we say
17 "No; that should be the charge for that service." This,
18 of course, excludes the consideration of the recommenda-
19 tion that had been made by the Thompson Committee --
20 I believe I am correct --- for deterrent or utilization
21 fees, whichever term you wish to use; and if they were
22 applied, of course, then the payment will have to be
23 made somewhere at some point by the person getting the
24 service.

25 COMMISSIONER FIRESTONE: Would there
26 be any set of circumstances where a physician could charge
27 a patient additional fees in addition to what he would
28 be paid under the scheme?

29 THE CHAIRMAN: For the services for
30 which he would receive payment from the scheme?

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a patient additional fees in addition to what he would

be paid under the scheme?

THE CHAIRMAN: For the service for

for he would receive payment from the scheme?



1 COMMISSIONER FIRESTONE: Correct, sir.

2 HON. MR. DAVIES: Yes, I am reminded

3 that the Act contains a clause with respect to specialists,
4 and if a person under the medical care plan were to walk
5 into a specialist's office and get service at that point,
6 the specialist would only be able to collect off him
7 the amount that the general practitioner would receive,
8 and the patient would be obligated to pay the balance.
9 However, if the general practitioner has referred the
10 patient to the specialist, then the total of the payment
11 will be put forward by the plan. The philosophy, as I
12 understand it, behind this is that the referral should
13 come from the general practitioner to the specialist,
14 and that to by-pass this chain is not a desirable thing
15 in the whole philosophy of medical care. I am probably
16 putting this a little clumsily, but I think it is
17 reasonably adequate.

18 COMMISSIONER FIRESTONE: It has been
19 the practice, particularly amongst surgeons, to vary
20 their fees depending upon the ability to pay, with people
21 in somewhat better circumstances perhaps paying a higher
22 fee than people in lower income brackets perhaps paying
23 a lower fee. Under your scheme would it be possible
24 for surgeons to vary the fees charged for the identical
25 surgical service?

26 HON. MR. DAVIES: I would take it
27 that the payment would be the same in all cases, and as
28 I understand it, again subject to correction, the theory
29 of the sliding scale is operated so that the poor patient
30 would presumably be charged less than the patient who



1 was more well-to-do, and somewhere along the line there
2 would be an evening out, so that an approximation of the
3 fair fee, if you can put it that way, would result. But
4 here, because the evening out process is presumably
5 accomplished through your financing structure, it is not
6 necessary to think of it in that fashion.

7 COMMISSIONER FIRESTONE: Assuming
8 that some arrangements like eighty-five per cent of the
9 fee schedule were to be worked out, or ninety per cent,
10 and assuming also that a somewhat different system
11 prevails in the neighbouring provinces where doctors will
12 be permitted to be paid one hundred per cent of the fee
13 schedule, wouldn't that put the physicians in Saskatchewan
14 at a disadvantage and make it more attractive for them
15 to practice in another province?

16 HON. MR. DAVIES: With respect, I don't
17 think so, for this reason: That if you conceive of
18 physicians in a neighbouring province not being under a
19 public medical care plan, and you must also conceive of
20 the usual charges that result to the physician for the
21 keeping of accounts and for the issuance of bills, and
22 sometimes I suppose the collection through other means,
23 all this is a relatively costly business which will
24 involve the expenditure of some sums of money on behalf
25 of each physician. I suggest these are not present
26 nearly to the same extent in the orbit of a public medical
27 care plan, and so in the analysis again the physician
28 actually should gain. This may be contested, but looking
29 at another aspect which I didn't mention --- that is,
30 what about the fees that for one reason or another are

fair fee, if you can put it that way, would result. But

the system of payment for services is not a simple one.

COMMISSIONER LAMBERT: Answering

and assuming also that a somewhat different system

prevails in the neighboring province where doctors will

be permitted to be paid one hundred per cent of the fee

schedule, wouldn't that put the physicians in Saskatchewan

at a disadvantage and make it more attractive for them

to practice in another province?

MR. LAMBERT: With respect, I don't

think so, for this reason: That if you compare of

physicians in a neighboring province and being subject to

public medical care plan, and you have also something of

the usual charges that result to the physician for the

keeping of accounts and for the issuance of bills, and

sometimes I suppose the collection through other means,

all this is a relatively costly business which will

involve the expenditure of some sum of money on behalf

of each physician. I suggest those are not present

nearly to the same extent in the orbit of a public medical

care plan, and so in the analysis again the physician

actually should gain. This may be overstated, but looking

at another aspect which I didn't mention -- that is,

at about the fees that for one reason or another are



1 uncollectable, that the physician in looking at the case
2 does not feel he can in conscience level a charge, and
3 I suppose this happens from time to time: This becomes
4 a bad debt and becomes something that is again a charge
5 on the operations of the physician. So, presuming these
6 two situation, it seems to me the physician will not be
7 so badly off.

8 COMMISSIONER FIRESTONE: Mr. Minister,
9 again on this question of definition, you speak in
10 paragraph G of your Summary that every person in Canada
11 has a right to necessary health services: Are necessary
12 health services the same as you define in paragraph C
13 as "basic health services"?

14 HON. MR. DAVIES: Yes, sir.

15 COMMISSIONER FIRESTONE: And on the
16 same point of definition, in paragraph 6 on page 2, you
17 say that every person in Canada has a right to a uniformly
18 high quality of health services: Is "uniformly high
19 quality health services" the same as "basic health
20 services" and "necessary health services"?

21 HON. MR. DAVIES: Yes; I think in
22 this they are practically synonymous.

23 COMMISSIONER FIRESTONE: Thank you,
24 Mr. Minister. In paragraph G you also speak on the basis
25 of ability to contribute: What would be your definition
26 of the basis of ability to contribute?

27 HON. MR. DAVIES: Well, I think, Mr.
28 Chairman, and Dr. Firestone, as everyone knows, this is
29 the kind of phrase that may be subject to some difference
30 of opinion, but we think of it here in the commonly



1 accepted nature of the term; that is, that there should
2 be a gradation of payment according to the earnings or
3 the returns of the income of the particular person. I
4 don't like to suggest the income tax basis because I
5 don't think it is in all respects completely equitable;
6 but it is this sort of principle that we are thinking
7 about here, and that persons obviously do have to a
8 greater or lesser extent in our society a greater or
9 lesser ability to contribute, and we should try to work
10 out something that is reasonably coherent in this kind
11 of scheme.

12 We may not be able to accomplish that
13 as nearly as we would like to but, in any event, I
14 suppose all I can say is it may not be what is suggested
15 on current arrangements that are in effect.

16 COMMISSIONER FIRESTONE: Does that
17 mean those who can afford it pay more for health services
18 then it would cost them to provide these health services
19 themselves? Does it subsidize those that cannot pay for
20 health services themselves?

21 HON. MR. DAVIES: - I think it means
22 that for some persons of higher income they will pay
23 more and for many people in lower income groups they
24 will pay less. However, overall there is a distribution
25 that considering the income of the particular person is
26 fair in that relationship.

27 COMMISSIONER FIRESTONE: I take it
28 from what you said earlier that the cut-off point would
29 be a family with two children earning \$6,000.00 or
30 \$7,000.00; that families below that level pay less than

of the form, that is, that there should be a graduation of payment according to the earnings or the returns of the income of the particular person. I don't like to suggest the income tax laws because I don't think it is in all respects completely equitable; but it is this sort of principle that we are talking about here, and that persons obviously do have to a greater or lesser extent in our society a greater or lesser ability to contribute, and we should try to work out something that is reasonably coherent in this kind of scheme.

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from what you said earlier that the out-of-pocket would be a family with two children earning \$6,000.00 or \$7,000.00; that families below that level pay less the



1 the cost of medical care services, and families of that
2 income level and above pay more than it would cost to
3 provide that service themselves. Am I right in that
4 understanding?

5 HON. MR. DAVIES: Yes. Again I
6 emphasize that these are rough estimates because it is
7 impossible to pinpoint it. I would think \$6,000.00 or
8 \$7,000.00 a year you would get to the point where you
9 were paying the same or somewhat more. As you advanced
10 beyond that you are paying more than you might pay on a
11 private plan again bearing in mind that the private plan
12 may not bear all the costs of a medical care programme.

13 COMMISSIONER FIRESTONE: We
14 appreciate your earnest endeavour to give us the best
15 estimate you can and accept all the figures you give us
16 in that respect.

17 May I now turn to paragraph H (a)
18 when you state:

19 " Need for health services is universal."

20 If I may present to you my understand-
21 ing of your definition of "universal" based on your own
22 submission and please correct me if the understanding is
23 not fully correct. I am referring to paragraph 7⁴ on
24 page 27 and I quote:

25 " We have concluded, after very
26 detailed examination of the problem, that
27 only a programme organized and financed
28 on a universal, province-wide basis can
29 arrange to provide and finance comprehen-
30 sive and uninterrupted medical care services."

HOW. MR. DAVIES: Yes. Again I

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\$1,000.00 a year you would get to the point where you
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When you state:

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ing of your definition of "universal" based on your own
satisfaction and please correct me if the understanding is
not fully correct. I am referring to paragraph IV on

page 27 and I quote:

"We have concluded after very

detailed examination of the problem, that

only a program organized and financed

on a universal, province-wide basis can

arrange to provide and finance comprehensive

and uninterrupted medical care services



1 I take it from this that your definition
2 of "universal" includes, one, province-wide; two,
3 comprehensive and, three, uninterrupted or continuous
4 medical care services.

5 HON. MR. DAVIES: Yes, I think so.
6 May I say, though, with reference to paragraph H (a)
7 where we speak of the need for health services being
8 universal, I think we use the word "universal" here in
9 the sense that everyone has a need for health services;
10 no one is excluded from the need. In other words, there
11 is a universality of need here.

12 COMMISSIONER FIRESTONE: I take it
13 that you first talk about need but then you try to
14 translate the need into a practical programme that will
15 take care of the need. We are now trying to assess what
16 are the criteria of that programme, and if I understood
17 you correctly your programme is intended to cover every-
18 one by province-wide basis, you will provide comprehensive
19 service and on an uninterrupted and continuous basis.
20 Those are the three criteria?

21 HON. MR. DAVIES: That is fair enough,
22 yes.

23 COMMISSIONER FIRESTONE: Then I take
24 it this programme has certain compulsory features from
25 the very nature of the definition?

26 HON. MR. DAVIES: Yes, the very fact
27 that the tax system that I outlined this morning is
28 operated conveys the fact that all people pay, all people
29 contribute.

30 COMMISSIONER FIRESTONE: I am quite



I take it from this last your definition

"universal" included, one covering what the

medical care services.

HON. MR. DAVIES: Yes, I think so.

May I say, though, with reference to paragraph 5 (a)

where we speak of the need for health services being

universal, I think we use the word "universal" here in

the sense that everyone has a need for health services;

no one is excluded from the need. In other words, there

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HON. MR. DAVIES: That is fair enough.

Yes.

COMMISSIONER WHEATSTONE: Then I take

it this programme has certain compulsory features from

the very nature of the definition?

HON. MR. DAVIES: Yes, the very fact

that the tax system that I outlined this morning is



1 happy to accept your explanation. I am trying to
2 establish this in essence by its definition of compulsory
3 programme. Now, you have suggested three means of
4 paying for the programme, the third one being a \$12.00
5 or \$24.00 payment per annum?

6 HON. MR. DAVIES: Per family.

7 COMMISSIONER FIRESTONE: Yes, \$12.00
8 single and \$24.00 per family per annum. Now, what
9 happens when somebody refuses to pay the \$24.00? I am
10 referring here to somebody who can afford to pay as
11 distinct from people who cannot afford to pay. What
12 happens?

13 HON. MR. DAVIES: I think we would
14 treat this in the same manner that we treat the similar
15 cases under hospitalization. There is an obligation to
16 pay and in cases where persons can pay and do not pay
17 we are entitled to and sometimes do initiate prosecutions.

18 COMMISSIONER FIRESTONE: Would you
19 in a case where somebody has not paid the \$24.00 fee,
20 would that person then be in a position that his card
21 which is required in order to obtain medical care services,
22 would there be no card? Would he be able to go and have
23 his examination, get medical service without any
24 presentation of ----

25 THE CHAIRMAN: I think he misunder-
26 stood you. Where payment is made there is a card.

27 DR. ROTH: Oh, yes.

28 COMMISSIONER FIRESTONE: Where payment
29 is made there is a card?

30 DR. ROTH: Yes.



Now, you have suggested three means of
paying for the programme, the third one being a \$12.00
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DR. ROTH: Oh, yes.

COMMISSIONER LESTER: Where payment

is made there is a card?



1 COMMISSIONER FIRESTONE: Where payment
2 is not made there is no card?

3 HON. MR. DAVIES: No.

4 COMMISSIONER FIRESTONE: Can you
5 obtain medical care services with no card if you are in
6 a position to pay?

7 HON. MR. DAVIES: We think of the
8 entitlement to this service as the possession of the card,
9 if you have that it signifies you are entitled to this
10 service. If you go into a hospital today in the Province
11 of Saskatchewan the presentation of your hospitalization
12 card is an indication that you have either partly paid
13 or wholly paid your hospitalization tax. I believe this
14 is the way this will work.

15 COMMISSIONER FIRESTONE: In other
16 words, if somebody does not have a card and he goes to
17 his physician and is examined and he cannot produce a
18 card, would the physician then be able to charge this
19 man for the services he has rendered? The man has not
20 got a card, the physician cannot collect it from the
21 pool, is he then allowed to charge this man?

22 HON. MR. DAVIES: Yes.

23 COMMISSIONER FIRESTONE: In other
24 words, if people do not want to co-operate under the
25 scheme they could refuse to pay and then make their own
26 arrangements with the doctor except you could prosecute
27 them and collect the \$24.00 whether they like it or not?

28 HON. MR. DAVIES: Yes. It would
29 be considered, as I have said, an obligation on that
30 person to pay if he can pay and if he cannot pay, of



COMMISSIONER FIRESTONE: Can you

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HON. MR. DAVIES: We think of the

entitlement to this service as the possession of the card if you have that it signifies you are entitled to this service. If you go into a hospital today in the Province of Saskatchewan the presentation of your hospitalization card is an indication that you have either partly paid or wholly paid your hospitalization tax. I believe this is the way this will work.

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HON. MR. DAVIES: Yes. It would

be considered, as I have said, an obligation on that person to pay if he can pay and if he cannot pay, of



1 course, the other means we have talked about would work.

2 COMMISSIONER FIRESTONE: But you would
3 not hold it against the doctor if the doctor collects a
4 fee from the patient?

5 HON. MR. DAVIES: I do not think so.
6 I do not think there is any reason to worry about it.

7 COMMISSIONER FIRESTONE: May I go to
8 paragraph J in which you say:

9 " We believe that the present operation
10 of our economic situation as it applies in
11 the field of personal health services is
12 failing to produce satisfactory results."

13 Can you just briefly elaborate what
14 you mean by this? Would you suggest, for instance, that
15 a proportion which Canada is devoting to health services,
16 the proportion of the gross national product is insuffi-
17 cient and therefore, we are not getting adequate health
18 services in Canada?

19 HON. MR. DAVIES: I would say that I
20 think we can devote a somewhat larger extent of our gross
21 product to health care without injuring ourselves.
22 Again I am not sure that all the moneys we are
23 expending now for health care is expended in the best way;
24 but to what I understand is the first part of your
25 question, it seems to me that first of all we do not
26 produce satisfactory results because we do not cover the
27 whole population. There are a number of persons who are
28 diseased, who are ailing because they are not able to
29 afford medical care. If you accept the fact that these
30 people do not pay because they simply cannot pay and



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fee from the patient?

HON. MR. DAVIES: I do not think so.

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COMMISSIONER FLINTSTONE: May I go to

paragraph 1 in which you say:

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of our economic situation as it applies in

the field of personal health services is

failing to produce satisfactory results."

Can you have better evidence that

you mean by this? Would you suggest, for instance, that

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Davies

1 ignoring, of course, those that can pay, who simply do
2 not, I think that would be a much smaller section we
3 have in the field of health care. Talking about the
4 private health plans, to begin with, here you have a
5 system where there has been worked out a payment to the
6 physician by a plan run by professionals which does not
7 really give doctors anything else in this orbit except
8 that single thing, the payment for that service. We do
9 not see that this encourages the class of health care
10 in a manner that we think can have the state of health-
11 iness that we have throughout this brief tried to project
12 that a measurement of this healthiness needs to be made.

13 THE CHAIRMAN: Is it implicit in
14 your answer that you contemplate the Commission use some
15 of this money that they get for other than administrative
16 expenses and the education of doctors, that they are
17 going to use that in any other way?

18 HON. MR. DAVIES: No. In the first
19 place we would have a plan that has no exclusions.

20 THE CHAIRMAN: The present plan?

21 HON. MR. DAVIES: The present plan
22 we are talking about and the one we intend to effect.

23 THE CHAIRMAN: You would be able to
24 use some of the money you got from the three sources
25 of taxation for preventive medicine in the sense of an
26 educational programme?

27 HON. MR. DAVIES: I do not think it
28 excludes an educational programme, I think that would be
29 a part of the plan. I would expect the medical care
30 commission in its wisdom would think about this kind of



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9 not see that this encourages the class of health care
10 in a manner that we think one have the state of health
11 means that we have throughout this first trial to produce
12 that a measurement of this performance needs to be made.

13 THE CHAIRMAN: Is it legitimate
14 your answer that you consider the Government has more
15 of this money that they get for other than educational
16 expenses and the education of doctors that they are
17 going to use that in any other way?

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19 place we would have a plan that has no exclusion.

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27 excludes an educational program, I think that would be
28 a part of the plan. I would expect the medical care



1 thing.

2 THE CHAIRMAN: But in the estimates
3 you have made for it have you included anything but the
4 cost of physician services plus administration?

5 HON. MR. DAVIES: I would have to
6 check with my colleagues on this and perhaps -- I am
7 informed that this is not the case.

8 THE CHAIRMAN: So there has been no
9 extra money in the present plan provided for these other
10 needs?

11 HON. MR. DAVIES: Apparently not, sir.
12 May I go on and say ---

13 THE CHAIRMAN: You could increase it
14 next year?

15 HON. MR. DAVIES: I am not now talking
16 about the medical care plan itself, I am talking about the
17 whole sector of public health. This is only one of the
18 arms of the Government and certainly ----

19 THE CHAIRMAN: The reason I put the
20 question to you is because you made the comparison to a
21 doctor sponsored plan which covered only those items they
22 use and the money for their specific purposes.

23 HON. MR. DAVIES: I was going on to
24 say the private plans do not cover all of the aspects of
25 medical care but there are some exclusions to the private
26 plans, some notable exclusions. There are also extra
27 charges. I am not sure, of course, in all the plans but
28 they apply in some. I am saying we do not think that it
29 covers the same area, the same wide area that we envisage
30 here. I am sorry that I misled the Commission on this



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here. I am sorry that I misled the Commission on this



1 question of education and things of that kind.

2 THE CHAIRMAN: It is not a matter of
3 misleading, it is a matter that we correctly understand.

4 COMMISSIONER FIRESTONE: Do I take it
5 that such things as exclusions or incomplete coverage
6 was one of the reasons that you have said in paragraph K
7 that the problems inherent in the organization of health
8 services require a large measure of responsibility to
9 be assumed by the government? Do I take it you would not
10 consider the extension of group medical services in the
11 Province of Saskatchewan on a comprehensive and universal
12 basis, on a voluntary basis as meeting with requirements?

13 HON. MR. DAVIES: I am sorry, I did
14 not locate this paragraph.

15 COMMISSIONER FIRESTONE: Paragraph K.
16 You say that the problem inherent in the organization of
17 health services requires a large measure of responsibility
18 to be assumed by the government. What the Commission is
19 trying to find out is, why? Now, you have enumerated
20 a number of things in your brief, and it is perhaps not
21 necessary to go over all those things, but I have a
22 specific question in that context. Could the objective
23 which your government has been achieved by using the
24 facilities of the group medical service plan in
25 Saskatchewan by extending it to everybody in the province
26 and perhaps by reducing the payments required for those
27 who cannot afford to pay the full premiums through some
28 subsidy arrangement? What is the objection to using an
29 already established co-operative plan that is working
30 successfully, to extend it on a province-wide basis?



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COMMISSIONER WINSTON: Do I take it

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services require a large measure of responsibility to

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consider the extension of group medical services in the

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already established co-operative plan that is working

successfully, to extend it on a province-wide basis?



1 HON. MR. DAVIES: In the first place,
2 I think our feeling is this: We have a plan that has
3 no particular responsibility except to the persons that
4 have formed that plan, that is, it has to render service.
5 You will then, if you follow through on what you suggest,
6 have a situation where government is effecting a level of
7 taxation for a subsidy to bonus a plan which is entirely
8 private in its origin and in its operations.

9 COMMISSIONER FIRESTONE: Non-profit.

10 HON. MR. DAVIES: Non-profit if you
11 like, but certainly with no public control.

12 COMMISSIONER FIRESTONE: Could the
13 public control not be introduced?

14 HON. MR. DAVIES: You still have the
15 same essential basis, I suggest, of a plan that has its
16 whole nature and its whole origin in those that are pro-
17 viding the services and those that presumably are not
18 entirely disinterested as of a whole lot of things that
19 make up that plan. I think this is the beginning of it.
20 The other part of it is that if you have a system where
21 the public through its governments is partly financing
22 the plan then why should not the public have a measure of
23 control, the broadest measure of control through the
24 public plan. Will it not really in the long haul work
25 best this way? The other thing is, it seems to me if
26 you envisage the bonusing of one plan, why not a dozen
27 plans, why not two dozen plans? What plan has another
28 particular additional merit than the other? This is
29 apart from the fact, I suggest, it is more expensive and
30 is not the best way of bringing this care to all people.



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22 public plan. Will it not really in the long haul work
23 best this way? The other thing is, it seems to me if
24 you envisage the possibility of one plan, why not a dozen
25 plans, why not two dozen plans? What plan has answered
26 particular additional merit than the others? This is
27 apart from the fact, I suggest, it is more expensive and
28 is not the best way of bringing this case to all people.



1 Now, there may be other things that can be added to this
2 thesis but these at least are some of them.

3 COMMISSIONER FIRESTONE: I take it the
4 reason why you do not wish to extend it to many plans,

5 some which are commercial, is quite understandable,

6 but I take it this particular plan is a non-profit plan

7 and there is presumably no objection to extending control

8 but you still feel even with the full control you would

9 not wish to use an existing framework that has been

10 developed and has worked well in the past. Presumably

11 the facilities are there and it worked well, and presumably

12 your own development has in mind doing some similar things

13 that this plan has done in effect.

14 HON. MR. DAVIES: I was going to say
15 that I think in the Thompson Committee Report if you have
16 had the opportunity to read it there is quite a section
17 and I do not want to read this all to you ----

18 COMMISSIONER FIRESTONE: What page?

19 HON. MR. DAVIES: Page 49, Public
20 Subsidization of Voluntary Insurance. I think this
21 question is dealt with reasonably well in these pages and
22 sets forth far better than I have done in a few words
23 what the objects are here.

24 THE CHAIRMAN: I do not think we are
25 working from the same pages.

26 HON. MR. DAVIES: It is page 49 called
27 "Public Subsidization of Voluntary Insurance.", It is
28 under the heading of "Considerations on the Basic Nature
29 of the Programme", and it goes on a bit, give or take a
30 page or so a little after that.



to may be other things that can be added to this

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some which are commercial, in other words, but I take it this particular plan is a non-profit plan and there is presumably no objection to extending control and you still feel even with the full control you would not wish to use an existing framework that has been developed and has worked well in the past. Presumably the facilities are there and it worked well, and presumably your own development can be used for some similar things that this plan has done in effect.

Substitution of Voluntary Insurance, I think this

sets forth the better, then I have done in a few words.

THE CHAIRMAN: I do not think we are

working from the same pages.

MR. J. DAVIS: It is page 9 called

"Public Substitution of Voluntary Insurance." It is



1 COMMISSIONER FIRESTONE: I am familiar
2 with it, Mr. Minister. I was just interested in your
3 own views, perhaps supplementing the views that are given
4 in this Report of the Committee. If you share the views
5 as expressed in this Report, all you have to say is this
6 is so, and we will take it as read.

7 HON. MR. DAVIES: Yes, I think that
8 broadly speaking I accept them. I don't know if I
9 accept every line and every paragraph.

10 COMMISSIONER FIRESTONE: No, I was
11 just referring in this specific context as to why you
12 prefer to use a government organization to an established
13 organization, even though you intend to use the same
14 things in the government organization as the private
15 organization, with extra control?

16 HON. MR. DAVIES: Yes, I feel what
17 I have said is in accordance with that feeling.

18 COMMISSIONER FIRESTONE: Thank you,
19 Mr. Minister. In that same paragraph, K, on page 2 of
20 your Summary, you say:

21 " We stress, however, that respon-
22 sibility for organization need not involve
23 the exercise of detailed control."

24 Could you give us some examples please?

25 HON. MR. DAVIES: If you will turn
26 to page 17, paragraph 46, and I shall not bother to read
27 it all, but it begins:

28 " We do not necessarily imply that
29 all organizational structures should be
30 under the direct control of government.



in this Report of the Committee. If you share the views
as expressed in this report, all you have to say is this
is so, and we will take it as read.

HON. MR. DAVIES: Yes, I think that
broadly speaking I accept them. I don't know if I
accept every line and every paragraph.

Just returning in this context as to why you
prefer to use a government organization to an established
organization, even though you intend to use the same
things in the government organization as the private
organization, with extra controls.

HON. MR. DAVIES: Yes, I feel that
I have said in accordance with what I said.
COMMISSIONER TIERNEY: Thank you.

Mr. Minister. In that same paragraph, K, on page 2 of
your summary, you say:

"We stress, however, that responsi-

bility for organization need not involve
the exercise of detailed control."

Could you give us some examples please?

HON. MR. DAVIES: If you will turn

to page 17, paragraph 16, and I shall not bother to read
it all, but it begins:

"We do not necessarily imply that

under the direct control of Government.



1 There are good examples in this province
2 where government stimulates organization
3 without the assumption of direct control."

4 And we go on here to give the example
5 of the operation of hospitals. Now, I think that is
6 what we make reference to in this Summary.

7 COMMISSIONER FIRESTONE: Yes, but
8 by referring me to this page, Mr. Minister, you speak
9 really of examples in the hospital field. I have in mind
10 examples in the medical care field, for example, would
11 the determination of standards of medical practice be
12 one of those things over which you would not exercise
13 detailed control? I am just trying to understand this
14 sentence in paragraph K as it relates to medical care.

15 HON. MR. DAVIES: I would think in
16 respect of specific direction, no. We would expect,
17 however, the Medical Care Commission to create, through
18 itself, those bodies that are spoken about in the
19 legislation, Medical Advisory Committees if my recollec-
20 tion is correct. These bodies are created with the idea
21 of getting the best possible advice and scientific
22 direction from personnel who are giving service, in this
23 case, the physicians, of course, and what we are saying
24 here is that the Government isn't dictating this from
25 the Department of Public Health, nor in essence is the
26 Commission, without the best of consultation and advice,
27 and I will point out also that in the legislation we
28 have a body known as The Advisory Council. This body
29 is to be set up of not more than twenty-five persons of
30 organizations in the Province that have an interest,



without the assumption of direct control."

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of the operation of hospitals. Now, I think that is

what we make reference to in this Summary.

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examples in the medical care field, for example, could

the demonstration of operation of medical practice be

one of those things over which you would not exercise

detailed control? I am just trying to understand that

sentence in paragraph 14 as it relates to medical care.

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however, the Medical Care Commission to create, through

itself, those bodies that are spoken about in the

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direction from personnel who are giving advice, in this

case, the physicians, of course, and what we are saying

here is that the Government must distribute this from

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and I will point out also that in the legislation we

have a body known as the Advisory Council. This body

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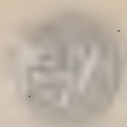
organizations in the Province that have an interest.



1 including the professional organizations, in medical
2 care, and if again referral is made to the Thompson
3 Committee Report, you will see the stripe of the body
4 that is referred to that could have representation on
5 this Advisory Council, and it has some rather broad
6 powers, and perhaps powers is the wrong word, but certain-
7 ly some very significant duties, and neither the
8 Commission nor the Government essentially proceeds with
9 new aspects of medical care, and indeed, with anything
10 that primarily affects the plan, unless this body is
11 consulted, so I suggest that here again is the kind of
12 thing we are talking about, where this direct or over-
13 weeing control if you like, isn't exercised. We try
14 to break it down to get to organizations, to get to the
15 people, and get their ideas, and indeed, direction.

16 COMMISSIONER FIRESTONE: Thank you,
17 Mr. Minister. I am familiar with your legislation and
18 the Advisory Council, but you come back to the specific
19 question, would the Commission state the standards of
20 medical practice on receipt of advice of this advisory
21 body, or would this be left to the physicians themselves.
22 I am just trying to understand this exercise of detailed
23 control as far as the practice of medicine in the
24 Province of Saskatchewan is concerned?

25 HON. MR. DAVIES: I don't think, sir,
26 that we would wish --- here I am speaking about a body
27 that we have created for the primary purpose of handling
28 day-to-day administration questions of the Commission
29 in relation to medical care, and have given it a good
30 many broad powers. It is true enough that there is



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this Advisory Council, and it has some control
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in some very significant duties, and whether the
Commission nor the Government essentially proceeds with
new aspects of medical care, and indeed, with anything
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thing we are talking about, where this kind of over-
we have control if you like, I am convinced. We try
to break it down to get to organizations, to get to the
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COMMISSIONER HENDERSON: Thank you.
Mr. Minister, I am familiar with your legislation and
the Advisory Council, but you come back to the specific
question, would the Commission raise the standards of
medical practice on matters of advice of this advisory
body, or would that be left to the physicians themselves.
I am just trying to understand this exercise of delegated
control as far as the practice of medicine in the
Province of Saskatchewan is concerned.
MR. MINISTER: I don't think, sir,
that we would wish -- here I am speaking about a body
that we have created for the primary purpose of handling
day-to-day administration questions of the Commission
in relation to medical care, and have given it a good



1 primarily legislative control that is exercised, but it
2 certainly isn't contemplated that it would be exercised
3 in any overweering sense, but I would think that the
4 operation of medicine, the points involved, the opinion
5 of a physician would govern and would guide the
6 Commission in all its aspects in this relation. I don't
7 think it could do anything else.

8 COMMISSIONER FIRESTONE: I take it
9 from what you say, Mr. Minister, that you would hope
10 that the Commission would permit physicians to run their
11 practice, but you are not binding the Commission to that
12 because you have given them a certain discretionary
13 power in this field. Am I right in this understanding?

14 HON. MR. DAVIES: We certainly do
15 not want to tell the physician how to run his show, how
16 to administer his patients, and in a word, how to give
17 the best medical care that he knows how. We presume
18 there are other professional bodies that regulate that,
19 and it is because of this that so much emphasis is
20 placed on the consultative relations of the Medical
21 Advisory Committee.

22 COMMISSIONER FIRESTONE: That is a
23 very reassuring observation. Thank you, Mr. Minister.
24 Paragraph O:

25 " The Government of Saskatchewan
26 expresses the hope that this Royal
27 Commission on Health Services can give
28 considerable attention to the means
29 whereby a nation-wide medical care in-
30 surance service can be implemented."



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 of a physician would govern and would guide the
 Commission in all its aspects in this relation. I don't
 think it could do anything else.

COMMISSIONER FLEMING: I take it
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 that the Commission would permit physicians to run their
 practice, but you are not binding the Commission so that
 because you have given them a certain discretionary
 power in this field. Am I right in this understanding?

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not want to tell the physician how to run his shop, how
 to administer his patients, and in a word, how to give
 the best medical care that he knows how. We presume
 there are other professional bodies that regulate that
 and it is because of this that so much emphasis is
 placed on the consultative relations of the Medical
 Advisory Committee.

Paragraph 6:

"The Government of Saskatchewan
 expresses the hope that this loyal
 considerable attention to the many
 whereby a nation-wide medical care
 service can be implemented."



1 If I understood you correctly, Mr.
2 Minister, in your earlier answers to questions that you
3 envisaged a programme whereby the Federal Government
4 would assist provincial schemes and plans in the light
5 of the existing constitutional division of responsibil-
6 ities?

7 HON. MR. DAVIES: Yes.

8 COMMISSIONER FIRESTONE: Mr. Minister,
9 you expressed the view in answer to a question that such
10 a national programme, as one of its prerequisites would
11 require or might require, I should say, universal
12 coverage, with a compulsory feature in each province
13 that was willing to accept the plan. Was I right in
14 that understanding, Mr. Minister?

15 HON. MR. DAVIES: So far as we are
16 concerned, we think these aspects are necessary. I don't
17 think this excludes from consideration provinces that
18 may have some different way in which to operate, and
19 they might determine in their own mind that this is the
20 way it should operate. Now, again the nation-wide
21 scheme that we envisage here, we think should have the
22 same features that we feel would be necessary here, and
23 we feel that the compulsory, and this sometimes becomes
24 I think, a dirty word, sir, but we think that these
25 compulsory features are necessary to bring to everyone
26 this standard of medical care that we think should be
27 basic, so that this might be part of the content that
28 would be required by a nation-wide plan, that there
29 would be some compulsory features of payment within it,
30 and this is the important thing in this concept, but
I don't think we would be so rash as to suggest that a



3 envisaged a programme whereby the Federal Government
 4 would assist provincial schemes and pass in the light
 5 of the existing constitutional division of responsibility
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 Mr. Minister: Yes, I think so.
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 this standard of medical care that we think should be
 basic, so that this might be part of the common fund
 would be regarded as a nation-wide plan, that there
 would be some compulsory features of payment within it,
 and this is the important thing in this concept, but
 I don't think we would be so rash as to suggest that



1 whole lot of means might not be worked out, that might
2 be more satisfactory to provinces, or to regions that
3 have different points of view. We think that the
4 effectual way to run it, administer it, to have a plan
5 that works, the way we think it should work, is to have
6 these features that we have urged.

7 COMMISSIONER FIRESTONE: Now, Mr.
8 Minister, if a Federal plan were evolved that would
9 (1) set minimum standards and (2) leave it to each
10 province whether the province wishes to have a compul-
11 sory or voluntary scheme, provided that in the case of
12 a voluntary scheme a given proportion of the population
13 is covered, say, seventy-five, eighty-five, or ninety-
14 five per cent, would such a Federal plan be acceptable
15 to the Province of Saskatchewan?

16 HON. MR. DAVIES: I can say this,
17 that if any other province works out a scheme that they
18 consider to be the best within their region, that
19 certainly it would be far from us to demand that they
20 follow out the same practice that we follow out, and
21 this is notwithstanding that we might not agree with it.
22 The thing is I suppose that any arrangement might be
23 better than none, even though we didn't think it was the
24 best way of carrying out these services, and in the long
25 run we didn't think it would be as satisfactory or
26 serviceable as the kind of plan that we urge. On the
27 other hand, we are one provincial jurisdiction, and we
28 are certainly not going to suggest that another pro-
29 vincial jurisdiction does not have the right and the
30 ability to work out some arrangement that is satisfactory



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five per cent, would such a Federal plan be acceptable
to the Province of Saskatchewan?

HON. MR. DAVIES: I am not sure.

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are certainly not going to suggest that another pro-
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1 to them.

2 COMMISSIONER FIRESTONE: Now, Mr.
3 Minister, if such a scheme were to come into effect,
4 would you feel that perhaps the same principle that was
5 used in putting into effect the Hospital Insurance Plan,
6 namely, that a majority of provinces represented the
7 majority of people of Canada, would be the basis on
8 which a medical care plan for Canada as a whole might
9 be implemented?

10 HON. MR. DAVIES: We would feel that
11 a majority is not necessary.

12 COMMISSIONER FIRESTONE: A majority
13 of provinces or majority of population?

14 HON. MR. DAVIES: A majority of
15 provinces. We would say that as long as a province wants
16 to introduce a plan of medical care such as we are urging
17 here, that reimbursement on the lines that we have
18 recommended should be instituted. I am not so sure
19 whether I would want to extend that particular principle
20 on the basis of an indiscriminate method of application
21 to all the provinces. I am not so sure. Certainly
22 nobody has talked about that in this Government. I haven't
23 discussed it with my colleagues or associates, and I
24 think we would want to take a look at that aspect, that
25 is if there was an indiscriminate application of
26 providing medical care services, whether this should
27 be permitted unless there was a majority of provinces
28 that sponsored it, but our position here is that we have,
29 or we are about to launch a medical plan, and that we
30 do need that assistance, and that that assistance is

COMMISSIONER FIRESTONE: Now, Mr.

Minister, if such a scheme were to come into effect, would you feel that perhaps the same principle that was used in putting into effect the Hospital Insurance Plan, namely, that a majority of provinces represented the majority of people of Canada, would be the basis on which a medical care plan for Canada as a whole might be implemented?

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1 altogether right and proper, and that moreover, it is
2 in line with so many of the proposals that were urged
3 as far back, by a Federal Government in 1945.

4 COMMISSIONER FIRESTONE: Did I
5 understand you to say that you wouldn't necessarily
6 feel that we should wait for a majority of provinces?
7 Would you still feel that the majority of population
8 should be covered before such a national plan came into
9 effect? You only made your qualification with respect
10 to majority of provinces. Does it also apply with
11 respect to majority of population?

12 HON. MR. DAVIES: We feel, sir,
13 quite frankly, that assistance to the Province of
14 Saskatchewan should begin when our plan goes into effect,
15 or as soon thereafter as possible.

16 THE CHAIRMAN: You are asking the
17 Federal Government to bail you out to the extent of
18 sixty per cent?

19 HON. MR. DAVIES: I wouldn't want to
20 use the word bail out.

21 THE CHAIRMAN: No, but that would be
22 the effect?

23 COMMISSIONER McCUTCHEON: Subsidize
24 is another word.

25 COMMISSIONER FIRESTONE: Mr. Minister,
26 perhaps if we can think a little bit about the sixty
27 per cent figure which is in the balance of this paragraph
28 O, page 3, you suggest that the Federal Government
29 assume at least sixty per cent of the cost of the
30 programme. Have you any suggestions, or would you leave



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perhaps if we can think a little bit about the sixty

per cent figure which is in the balance of this paragraph.

O. page 3, you suggest that the Federal Government

assume at least sixty per cent of the cost of the



1 it to the good judgment of the Federal Government how
2 it should raise its sixty per cent?

3 HON. MR. DAVIES: Well, there are,
4 as you know, Dr. Firestone, a wide range of measures
5 by which, and ingeniously which the Federal Government
6 raises money. I don't think we presume to say here how
7 much, nor do we want to be thought of as being extreme,
8 and saying that we as one province should be covered
9 while other provinces have not as yet come around to that
10 decision. But on the other hand, we do think that some-
11 thing can be worked out in the methods of taxation,
12 imposts, that are placed upon the population to make an
13 equitable means of payment. Now, when I said that we
14 did think that this Province should receive assistance
15 forthwith, I say it with the thought that it may be
16 some time before this kind of a proposal is acceded to.
17 On the other hand, we do not think that under the cir-
18 cumstances, considering especially the principles of
19 proposals that have been made during the past in this
20 country from governmental sources, that we should be
21 obligated to wait for an unconscionable length of time
22 before this assistance is granted to the Province.

23 COMMISSIONER FIRESTONE: Now, Mr.
24 Minister, if the Federal Government were to raise its
25 income tax rate to pay for such a national plan, would
26 this not run contrary to the principle of the Federal
27 Government reducing the income tax rates to leave more
28 room for provinces to collect income tax for urgent
29 provincial programmes, including health plans?

30 HON. MR. DAVIES: I think the



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1 difficulty here, Mr. Chairman, is simply the difficulty
2 that we in this country have tremendously varying
3 abilities to pay. The Province of Ontario, the Province
4 of British Columbia, with a great deal more industry and
5 a great deal more taxation bases, have a better chance
6 of providing those services than many other provinces do,
7 and I don't think that we can consider as equitable
8 merely the granting of rights to apply income tax, say
9 in the Maritimes, Newfoundland, or parts of the Prairies,
10 Saskatchewan certainly would be an example here, because
11 this wouldn't reflect equitability, it would give you
12 in fact a condition where you were paying much more for
13 the things that you wanted than would be the case if
14 this taxation were applied nation-wide, and I suggest
15 to you, Dr. Firestone, that this is entirely the
16 principle that at least previous Federal Governments
17 have worked upon, namely, that there would be some
18 equitability in this financing arrangement.

19 COMMISSIONER FIRESTONE: Now, let us
20 assume, Mr. Minister, that the Federal Government were
21 to make a sixty per cent contribution, as you have
22 suggested in this paragraph. How would this amount be
23 used by the Government of Saskatchewan? Would it be
24 used to expand medical care services, or health services
25 beyond what you are doing now, for example, to go into
26 the field of dental care and the field of pre-paid drug
27 plans, and other programmes, or would you use it to
28 reduce the taxes or other means of payment?

29 HON. MR. DAVIES: Well, my instant
30 thought, Dr. Firestone, is that we would like to use

difficultly here, Mr. Chairman, is simply the difficulty
of providing those services that many other provinces do,
and I don't think that we can consider as equitable
merely the granting of rights to apply income tax, say,
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COMMISSIONER FRIESEN: Now, let us
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beyond what you are doing now, for example, to go into
the field of dental care and the field of pre-paid drug
plans, and other programmes, or would you use it to
reduce the taxes or other means of payment?

HON. MR. DAVIES: Well, my friend



1 this amount to defray the costs of medical care, but this
2 certainly wouldn't exclude the other possibilities that
3 you have suggested, and as a matter of fact, I suppose
4 to some extent this is what is taking place, since we
5 received the Federal contribution for our hospital care.
6 Really, I cannot give you a direct answer to that. It
7 depends on a great number of variables. Certainly we
8 think that this is in line with the suggestion that was
9 made, again I emphasize in 1945, that sixty per cent
10 should be applied as a set-off by the Federal Government.

11 COMMISSIONER FIRESTONE: You would
12 be in receipt of sixty per cent of \$20.00 million, which
13 would be \$12.5 million, and you could do something with
14 that money, either use it for additional health services,
15 or you can reduce taxes, or you might do both, and as I
16 understand your answer, sir, it is that you will make
17 your decision when you get the money?

18 HON. MR. DAVIES: Yes, I don't think
19 that that kind of policy decision could be made at this
20 time, without knowing any one of the variables I have
21 spoken about, because this is a prime matter of policy.
22 I think a decision would have to be made at that time.
23 I don't think they are necessarily excluded, and I don't
24 think they are necessarily included.

25 COMMISSIONER FIRESTONE: But I take it,
26 Mr. Minister, that you have some long-range plans. You
27 have looked at medical care services as one step in the
28 direction of a total or universal programme, as you have
29 it in mind, and therefore, it would be a reasonable
30 supposition that if some of the costs were shared, this



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received the Federal contribution for our hospital care.
Really, I cannot give you a direct answer to that. It
depends on a great number of variables. Certainly we
think that this is in line with the suggestion that was
made, again I emphasize in 1945, that sixty per cent

should be applied as a set-off by the Federal Government.
COMMISSIONER FIRESTONE: You would

be in receipt of sixty per cent of \$20,000 million, which
would be \$12.5 million, and you could do something with
that money, either use it for additional health services,
or you can reduce taxes, or you might do both, and as I
understand your answer, sir, it is that you will make
your decision when you get the money?

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1 would enable you perhaps to move to a second stage in
2 your long-range term programme, which you might find
3 difficult in implementing at the present stage?

4 HON. MR. DAVIES: There would be no
5 difficulty whatsoever, Dr. Firestone, if they would apply
6 the sixty per cent on the new services that we intend to
7 institute, but if we had to apply the sixty per cent, not
8 on the new services we are providing, but on other
9 services, this would require a great deal of thought,
10 and certainly a policy decision, but I think we would
11 feel this way too, that if there were other necessary
12 services, whatever necessary is construed as, we would
13 like to look at the time when the sixty per cent would
14 apply in a broader range than simply medical care.

15 COMMISSIONER FIRESTONE: Thank you,
16 Mr. Minister. I turn now to paragraph 8 on page 3, the
17 last line of that paragraph, where you say that you expect
18 governments to work in co-operation with all elements of
19 the social order. Applying this endeavour to co-operate
20 to Saskatchewan, does "co-operation" in this context
21 mean more than just setting up the advisory council about
22 which you told us a little earlier?

23 HON. MR. DAVIES: I think it simply
24 means what it says, sir, that we want a situation where
25 the government can work in co-operation with all the
26 elements that are affected, and as closely as possible,
27 and in as great a harmony as possible.

28 COMMISSIONER FIRESTONE: I take it
29 these sectors include the medical profession?

30 HON. MR. DAVIES: This would certainly



would enable you perhaps to move to a second stage in
the future, but I think it is better to be prepared
for the possibility of a second stage in the future.
There would be no difficulty whatsoever, Dr. Firestone, if they would apply
the sixty per cent on the new services that we intend to
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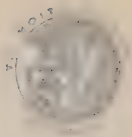


1 include the medical profession.

2 COMMISSIONER FIRESTONE: May I now
3 turn to page 4 where beginning with paragraphs 11, 12,
4 13 and so on, you talk about the desirability of a number
5 of studies to measure the state of health of the nation,
6 and what is described as the sub-health: Is the purpose
7 of these studies to assist among other things the
8 impact of improved health on the ability of the nation
9 to produce and to increase productivity?

10 HON. MR. DAVIES: This would be
11 certainly the prime objective. On the other hand, I
12 think more primary than that is simply to have good health
13 for the sake of good health and for the happiness of the
14 individual. This is surely the first and foremost thing.
15 But, on the other hand, one of the direct results is
16 unquestionably that we would have through a state of
17 better health of all of the individuals in our society
18 a greater production, because the number of days that are
19 lost of working people, farmers, professionals, and
20 others in Canada because of ill health must be very
21 large, and the amount of money, if estimated, must be
22 almost astronomical. Certainly, one of the beneficial
23 side effects of spending \$X or X per cent of your
24 national income, if you want to put it in that fashion,
25 is that we will gain by an enhanced production, but I
26 like to think first and foremost that our objective is,
27 in a word, the happiness of the individual through a
28 state of healthiness as, again, we try to describe it
29 in the brief.

30 COMMISSIONER FIRESTONE: Would you



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COMMISSIONER FIRESTONE: Would you



1 say if we had a better understanding of what good health
2 can do to raise productivity of the nation, that this
3 might provide an inducement to devote a greater pro-
4 portion of our resources to health services?

5 HON. MR. DAVIES: It would almost
6 seem obvious that the answer is yes. I think that as
7 you do have a larger pot to take things from, there is
8 more reason to buy things that are good in these terms,
9 but, of course, this is not always entirely the case,
10 because of choices that are made for other reasons:
11 Choices that are induced by, say, high pressure advertising.
12 People don't always spend the amounts of money they
13 should do for the best things, but within the broad orbit
14 I think there is no question that as you are able to
15 get a larger national income you have a much better
16 argument for spending larger amounts for these good
17 purposes. But I would also argue that even if you did
18 not have that larger production, even if you had only
19 the status quo of production, there is every good argu-
20 ment for a basic system that provides the best in terms
21 of healthiness for the individual.

22 COMMISSIONER FIRESTONE: Mr. Minister,
23 in paragraph 35 on page 12 you refer to,

24 "... well under five per cent of
25 the gross national product is being devoted
26 to personal health care services."

27 Then, you continue on page 13 and you
28 say:

29 "One of the most crucial questions
30 in this area, which deserves much research



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1 and consideration, is the matter of whether
2 we should commit a higher proportion of
3 our national productivity to health purposes."

4 Now, the Commission will be engaged
5 in the type of studies which you outline in this paragraph,
6 but we are interested in your own views, representative
7 views of the Government of Saskatchewan. Do I take it
8 that you are not only interested in the Commission under-
9 taking studies, but that you would recommend to us that
10 over the next so many years we should devote a higher
11 proportion of our gross national product? We are devoting
12 if you take for example the five per cent figure you have
13 quoted -- or close to it -- on the basis of our gross
14 national product for 1961, we are devoting close to
15 \$2 billion, and that \$2 billion figure would then be
16 reached perhaps for sure in another year or two. As we
17 reach a gross national product of \$40 billion, a one
18 per cent increase would be \$400 million. Would you be
19 in favour as part of a target, as part of the direction
20 in which the national health programme should aim, is
21 to increase our proportion, say, five per cent of our
22 gross national product to, say, six per cent over a
23 period of five years, or something like \$400 million,
24 and then by another per cent over the next five years,
25 and that may be equivalent to \$500 million in view of
26 our gross national product? Is that the overall target
27 you have in mind?

28 HON. MR. DAVIES: I think I would
29 like to see -- and we are getting into the orbit of
30 personal opinions in some ways, but they do hinge on



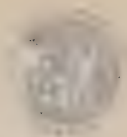
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HON. MR. DAVIES: I think I would

like to see -- and we are getting into the orbit of
personal opinions in some ways, but they do hinge on



1 the brief, and I would like to think as the economy
2 expands, that part of that expansion would be devoted
3 not only to television sets, refrigerators and longer
4 cars, but part of that would be devoted to not only
5 improved health care but all those other social services
6 that are constantly being urged upon governments. So
7 to that extent I would think that a much better argument
8 would be constituted for paying for those things with
9 the larger fund with which to do so. On the other hand,
10 I would not like to accept that moneys would only be
11 spent if your gross national product were to expand,
12 because this would make health then dependent upon that
13 one thing which would not be desirable. So, it is very
14 hard to answer with a straight yes or a straight no.
15 But, I think what we tried to think of here, when we say
16 one of the most crucial questions in this area, which
17 deserves much research and consideration, is the matter
18 of whether we should commit a higher proportion of our
19 national productivity to health purposes, is the fact
20 it is extremely important to have from the public
21 acceptance of what we are aiming at in all these programmes,
22 because, again, of the conflicting demands and pressures
23 on the public to spend their money, and this is certainly
24 something the public generally is becoming more increasingly
25 aware of. But a programme for education of the public
26 to sort of indicate the choices that can be made, to
27 point out that five per cent of the gross national product
28 is by no means an exorbitant figure to get this level
29 of health and happiness we are talking about, is a desir-
30 able thing and one they should themselves as an



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1 intelligent section strive for.

2 COMMISSIONER FIRESTONE: May I now
3 turn to a statement of principles which are elaborated
4 at the top of page 15 at the end of your paragraph 38.
5 You speak here in paragraph (a) of a planned approach
6 to large-scale organization of health care services to
7 achieve a more efficient distribution and use. What did
8 you have in mind when you speak of a more efficient
9 distribution and use?

10 HON. MR. DAVIES: I think we are
11 thinking here of all of the manifold areas that we now
12 have that are making attempts in the direction of better
13 health. We are thinking not only of medical care
14 programmes, of preventive programmes, of the efforts of
15 voluntary agencies, but we wonder whether in the
16 application of the efforts of each of these areas there
17 should not be, as we say, a more efficient distribution
18 and use. So that we say that a planned approach to this
19 organization is a desirable thing, and I think we
20 indicate here that the public sector is an extremely
21 important area to do this work, and I want to point out
22 again we are not talking about this direct control. We
23 are talking about a sort of partnership, if you will;
24 co-operation and co-ordination of all these agencies
25 and of all these areas that have anything to do with the
26 broad sector of health.

27 COMMISSIONER FIRESTONE: In paragraph
28 (b) you also speak of a stable, flexible and equitable
29 system of meeting the expenditures involved in providing
30 health services. What did you have in mind by the three

1961-1962

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broad sector of health.

COMMISSIONER FIRSTONE: In paragraph

system of meeting the expenditures involved in providing



1 adjectives, "stable, flexible, equitable"?

2 HON. MR. DAVIES: Well, I suggest
3 that we have been talking probably about this during the
4 last hour or so; that is, we talk about flexibility in
5 terms of differences in the programmes, although the
6 adequate basic set-up to provide what is desirable for
7 the purposes of medical care or any other programme ----

8 COMMISSIONER FIRESTONE: But may I
9 ask, Mr. Minister, on flexibility, does it mean in the
10 light of experience that you may cut down one programme
11 and expand another? What does "flexibility" mean?

12 HON. MR. DAVIES: Flexibility might
13 mean that, sir, especially if one programme had been
14 targeted too heavily, but not necessarily so.

15 COMMISSIONER FIRESTONE: Then, your
16 medical profession may say, "We advise you strongly
17 against cutting down this programme." through your
18 advisory council: Could you visualize a conflict of
19 interests developing?

20 HON. MR. DAVIES: No, sir. I have
21 never yet met any body including government, where there
22 has not been a conflict or argument over something, and
23 I think these take place in a democratic society, and I
24 suppose as long as we live we are going to see it, but
25 somehow along the line we work things out. Sometimes
26 they are worked out rather roughly. Certainly, we would
27 like to do nothing of this kind as a government without
28 the maximum consultation. I want to remind you again
29 that the urgings of private organizations have not always
30 historically been correct, and I think there are abundant



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1 examples that may be cited here to show what I mean.
2 In any event, I believe the word "flexible" here is not
3 only in that particular area, but in terms of having
4 something different in some of the regions and some of
5 the provinces, if you like; not having a monolithic
6 sameness, because this won't come about.

7 "Stable," I think, must mean that you
8 won't have something that fluctuates from year to year,
9 so that you don't have a desirable programme with long-
10 term results, and particularly, of course, financing.
11 You could hardly have one-quarter of the amount given
12 one year that was given during the previous year.

13 "Equitable": Well, equitable in terms,
14 of course, of the burden on everyone; equitable in terms
15 of trying to be reasonable with those who are giving
16 the service and those who receive it.

17 COMMISSIONER FIRESTONE: In paragraph
18 (c) you speak of a means of allocating responsibility
19 in the health field between the citizen as patient and
20 taxpayer, all levels of government, the voluntary health
21 agencies, and the various professions involved in providing
22 health care. There did you have in mind, when speaking
23 of allocating responsibilities, as far as it affects the
24 various professions -- have you in mind any changes in
25 the responsibilities of the medical profession?

26 HON. MR. DAVIES: Not in particular,
27 Dr. Firestone. The meaning here is that if you assume
28 this particular field of health we have been talking
29 about for several hours, and assuming there are a number
30 of professional groups operating within this sector and

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HON. MR. DAVIES: Not in particular.
Dr. Firestone. The meaning here is that if you assume
this particular field of health we have been talking
about for several hours, and assuming there are a number
of professional groups operating within this sector and



1 levels of government, all agencies, and so forth, what
2 we are really saying here is that you some how have to
3 assess even in general terms where responsibilities
4 properly lie. I suppose there could be many examples
5 given of voluntary agencies where their targets are not
6 met and where their objectives are not met because there
7 has failed to be at some stage a suitable allocation of
8 responsibility. We take this as something that is not
9 very simple; certainly not as simple as a government
10 saying, "You perform this service and this other number
11 of professions perform that." We don't envisage that,
12 but we do envisage a consultation of all concerned, and
13 as a result of that consultation there will be a general
14 acceptance of the role of each agency, of each level of
15 government, and each person or agency concerned --
16 where they belong for a provision of the ideal healthiness
17 that we are talking about.

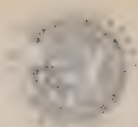
18
19 --- A short recess.

20
21 THE CHAIRMAN: Ladies and gentlemen,
22 if you will come to order we will proceed.

23 COMMISSIONER FIRESTONE: If I may now
24 turn to paragraph 55 on page 20, you say:

25 " ... the prime responsibility of
26 government at all levels is to plan compre-
27 hensively for the development of appropriate
28 health services."

29 Can you advise the Commission of how
30 this planning process can best be carried out on a



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12 as a result of that consultation there will be a general
13 acceptance of the role of each agency, of each level of
14 government, and each person or agency concerned --
15 where they belong for a provision of the local health
16 that we are talking about.

17 --- A short recess

18 THE CHAIRMAN: Ladies and gentlemen,
19 if you will come to order we will proceed.
20 COMMISSIONER THOMPSON: If I may now
21 turn to paragraph 55 on page 20, you say:
22 "... the prime responsibility of
23 government at all levels is to plan compre-
24 hensively for the development of appropriate
25 health services."
26 Can you advise the Commission of how
27 this planning process can best be carried out on a



1 continuing basis within a federal framework?

2 HON. MR. DAVIES: Well, I suppose I
3 can speak better of our provincial framework which is
4 what I have been thinking most about. Obviously as far
5 as this sort of line is indicated representatives of
6 the federal and provincial governments must naturally
7 be thought of in the beginning of a thing of this kind,
8 and the representatives too I suggest of the local
9 governments. My understanding is that there are some
10 forty-six hundred local governments in Canada and I would
11 think their participation in this sort of co-ordinating
12 fact finding, policy making, or policy discovering
13 programme would be extremely important, and the main
14 organization concerned in public health or health of all
15 kinds I should properly say. There are the national
16 organizations of labour, management, farmer, co-operatives,
17 in a word, I think that planning should pre-suppose an
18 experimental opportunity of consultation. Now, ultimately
19 it seems to me that this may be brought down to the
20 three government levels for the finalization of the
21 policy which you are trying to work out. I think pro-
22 ceeding in the way of discovering of what we want, we
23 need to go and need to involve all the bodies that have
24 in any way anything to do with the problem that is being
25 discussed. In the final analysis I suggest again and we
26 suggest here it is the main responsibility of government
27 and again government at all levels to do the planning
28 and to do the actuating.

29 COMMISSIONER FIRESTONE: Have you
30 any concrete suggestions for continuing federal-



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1 provincial machinery in the field of developing and
2 financing health programmes in Canada?

3 HON. MR. DAVIES: Well, I suppose the
4 thing that springs logically to the mind as a beginning
5 is the first thing I talked about and that is the
6 mechanism that involves the three governments, provincial,
7 federal and municipal. I would not exclude the others
8 but I think those are the primary ones, I think they
9 would very well be able to meet annually or bi-annually
10 to discuss the objectives and try and find what the
11 people are wanting, where they are looking, what to aim
12 for. It is very difficult for me to say directly, I
13 suppose, just how large this involvement should be or
14 how great this consultation apparatus should be. In any
15 event, I suppose the nucleus of it would be the govern-
16 ments at the three levels.

17 COMMISSIONER FIRESTONE: I take it
18 from what you say that you visualize consultation on
19 a continuing and regular basis between the different
20 levels of government, and I take it further that
21 consultation between the provincial government and the
22 municipalities is a matter wholly within the jurisdiction
23 of the province and at their discretion and, therefore,
24 if we are talking in terms of federal-provincial co-
25 operation or consultations we might think in more limited
26 terms as far as the terms of reference of this Royal
27 Commission is concerned? Would you be in favour of an
28 annual federal-provincial conference of health methods
29 which would represent the progress made, problems
30 encountered and deal with alternative ways of coming to



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COMMISSIONER FLETCHER: I take it from what you say that you visualize consultation on a continuing and regular basis between the different levels of government, and I take it further that consultation between the provincial government and the municipalities is a matter wholly within the jurisdiction of the provincial government. If we are talking in terms of federal-provincial co-operation or consultation we might think in more limited terms as to the scope of the consultation. I think that which would represent the progress made, problems encountered and deal with alternative ways of coming to



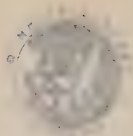
1 grips with some of the problems that are being faced.

2 HON. MR. DAVIES: I am not sure who
3 it should involve but I am in favour of a regular and
4 continuing meeting to pinpoint matters of this kind. You
5 mentioned the municipalities and, of course, you are
6 quite right about the municipalities being the creatures
7 of the provinces, and yet we have the national body,
8 the Association of Mayors and Municipalities which has
9 a somewhat broader function. I think this body might be
10 directly involved in the more detailed or the larger
11 consultation; It is possible if you think in terms of
12 agencies besides the three levels of government.

13 COMMISSIONER FIRESTONE: I am sure
14 one can think of many agencies but in order to make the
15 thing workable and practicable I presume that the
16 Province of Saskatchewan would support an annual confer-
17 ence of Ministers of Health concerning health matters on
18 a national and provincial level even though this
19 conference might only include the Minister of Health
20 of the Federal Government and the Ministers of Health of
21 the ten provinces. Would you support such a conference?

22 HON. MR. DAVIES: If you do not mind
23 I would like Dr. Roth to comment on this because I know
24 he has some ideas and he can elaborate on them.

25 DR. ROTH: I think we will have to
26 recognize that at the present time there are some formal
27 ways in which the health authorities at the provincial
28 and federal level consult each other. The oldest of
29 these is the Dominion Council of Health which has been
30 meeting for a great many years and it represents, as you



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28 and federal level consult each other. The oldest or
29 these is the Dominion Council of Health which has been
30 meeting for a great many years and its representatives, as you



1 know, the federal Deputy Ministers of Health and ten
2 provincial deputies plus other people who represent,
3 broadly, the people receiving services plus a scientific
4 adviser who serves in the council. In addition to this
5 with the implementation of the hospital insurance agree-
6 ment of 1958 provision was made for the setting up of
7 a formal advisory committee to the National Minister of
8 Health. This meets twice annually and there are a series
9 of sub-committees which deal with the technical problems.
10 They meet regularly as well, and in some cases, meet
11 twice annually. There is also provision for the setting
12 up of expert working parties. The question I think that
13 is in your mind is whether there should be one sort of
14 super body of consultation or whether this consultation
15 should take place in certain specified fields. In other
16 words, as we move ahead into a medical care programme
17 and then into a dental care programme, and then into a
18 pharmaceutical programme, and so on, if this is the way
19 in which we move, do we then set up consultation on
20 these specific topic areas or do we set up a sort of
21 super body composed of the Ministers of Health to talk
22 about problems of federal-provincial relationships and
23 alternatives and so on? My own opinion for what it is
24 worth, is that we need both.

25 COMMISSIONER FIRESTONE: Thank you
26 very much for elaborating on what is actually being done.
27 As you quite rightly point out most of these discussions
28 are of a technical and administrative nature or advisory
29 nature conducted by civil servants or advisers. I am
30 referring to paragraph 55 which specifically speaks of



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As you quite rightly point out most of these discussions
are of a technical and administrative nature or advisory
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1 the prime responsibility of government at all levels is
2 to plan comprehensively for the development of appropriate
3 health services. As you know, when you do some planning
4 all the civil servants and advisers can do is make
5 proposals but the people who make the decisions are the
6 people that are responsible to the people of their
7 respective provinces or the people of Canada, their
8 elected representatives. Therefore, if there are matters
9 of policy to be discussed, I presume planning does not
10 only involve making suggestions but also being interested
11 in how to implement those suggestions, that you would need
12 a policy maker to participate in the planning process.
13 Am I right in this assumption?

14 HON. MR. DAVIES: I do not think I
15 would contest that at all that if you are going to have
16 something done finally you have to have the policy makers
17 understanding what they are doing. Probably it is
18 desirable to have them altogether in one room when this
19 takes place. If the things you are trying to do nation-
20 wide are carried out I certainly would not dispute that.

21 COMMISSIONER FIRESTONE: Would you,
22 therefore, be in favour of a federal-provincial conference
23 of Ministers of Health concerned with matters of planning
24 and discussing this overall programme supported by what-
25 ever committees or sub-groups of working parties that
26 are required of civil servants?

27 HON. MR. DAVIES: If this is the means
28 contemplated we would be happy to work within that frame-
29 work.

30 COMMISSIONER FIRESTONE: I am just



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COMMISSIONER FLEWELLER: Would you, therefore, be in favour of a federal-provincial conference of Ministers of Health concerned with matters of planning and discussing this overall programme supported by various committees or sub-groups of working parties that are required of civil servants?

HON. MR. DAVIES: It is this is the means I am just

COMMISSIONER FLEWELLER: I am just



1 trying to establish how the objective that you have set
2 up in this paragraph can be achieved, and I take it that
3 the answer is federal-provincial consultation by federal
4 ministers is one way of going about it?

5 HON. MR. DAVIES: Yes, I think you
6 must have them come together in some way of that kind.

7 COMMISSIONER FIRESTONE: If I might
8 turn to page 25 and page 26, paragraph 69. You set out
9 in this paragraph 69 four ways in which a programme can
10 be developed, and the last of the four is to develop and
11 introduce concurrently a total health programme. Now,
12 of the four ways that are outlined here, which of the
13 ways would your own government consider the most desirable
14 way of approaching the development of a comprehensive
15 universal health programme?

16 HON. MR. DAVIES: I think that we
17 would feel that probably they have come a fair distance
18 along the road. In respect to C I think this is probably
19 the area that we are now talking about. Now, D, "to
20 develop and introduce concurrently a total health pro-
21 gramme" may result because of the first three. Ideally,
22 I suppose, and what in this light is ideal, is that you
23 are envisaging something that would work for the health
24 of everyone, the best, you talk simply in the beginning
25 of getting a total health programme, getting everything
26 you did in the first, A, B, and C, plus a little bit
27 more. There is simply I suppose some thought about how
28 to get to your objective. Ideally, again, D would be the
29 best but I am not sure -- perhaps I should not say I am
30 not sure, I am rather sure that we want to be able to do



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1 it in that fashion.

2 COMMISSIONER FIRESTONE: I take it
3 then you would be in favour of developing an overall
4 health programme in stages?

5 HON. MR. DAVIES: This is in fact
6 what we have done.

7 COMMISSIONER FIRESTONE: Now, in
8 developing such a programme in stages have you set any
9 priorities? I would like to be a little more specific
10 on this priority question because it may be a general
11 question. Have you any advice to offer to the Royal
12 Commission in its own deliberations as to what the federal
13 government can do if the federal government were to em-
14 bark on an extended health programme. What parts of that
15 health programme would you like to see the federal
16 government implement first or in the order of priority,
17 first, second, and third? Would you include, for instance,
18 the first priority the extension of federal health grants?
19 Would you put into a second priority participation in
20 a universal medical care plan? Would you put in the
21 third priority the development of a dental care plan?
22 Would you put into a fourth priority the development of
23 a drug plan? Would you put into a fifth priority the
24 development of other health services, optical services,
25 etcetera? Have you any advice to offer us how the limited
26 means may be at the disposal of the federal government
27 can best be used to develop a health programme and to
28 help provinces develop their own health programme in the
29 manner of the most efficient and most helpful to the
30 province?



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1 HON. MR.DAVIES: It is our feeling,
2 of course, that the order we have proceeded in is the
3 one we would like assistance on. That is to say, at this
4 point we would indicate we would like priority in the
5 direction of assistance to a medical care plan. It seems
6 to me that some of the means you have suggested should
7 run concurrently with that, for instance, the question of
8 federal grants. Now, I think it would be almost
9 impossible to divorce the question of grants from any
10 health programme let alone a medical care programme, so
11 we should think those should run concurrent with any
12 extension, and, of course, more pertinently, the grants
13 programme that would complement the medical care programme
14 that we are about to bring into being. Now, I suppose
15 I should also say that we have indicated our priority
16 here by proceeding with the medical care plan instead of
17 a dental plan. We think this should have priority at
18 this time, but this does not exclude the prospect of this
19 being included as time goes on, and as the opportunity
20 avails itself. I say it is also very difficult to say
21 just how priority would be next year or the year after.

22 I think generally I would like to sum
23 up again by saying that we would like the type of priority
24 given that would fit best in with the programmes that we
25 are trying to develop, and that the health grants
26 programme could hardly be separated from the assistance
27 to the medical care plan. Now, of course, if it were
28 thought that assistance couldn't be rendered now in that
29 fashion, that wouldn't exclude something being done, we
30 hope, in the field of grants or in the remuneration

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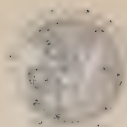
1 suggested for sanatoria and mental care. These things
2 could certainly take place, we believe, without assist-
3 ance being rendered in the medical care sector.

4 COMMISSIONER FIRESTONE: May I now
5 turn, Mr. Minister, to paragraph 76, on page 28, the
6 last line, where you say:

7 " The Federal role, as in the field
8 of hospital insurance, should be to establish
9 the content of a nation-wide programme to
10 insure uniform terms and conditions for all
11 citizens, to provide consultative and advisory
12 services to the provinces,"

13 What consultative and advisory services
14 did you have in mind, sir?

15 HON. MR. DAVIES: Well, I think here
16 again, Dr. Firestone, I shall ask some of my associates
17 who are present to elaborate on what I am about to say,
18 but I would think that consultative in the sense of the
19 kind and type of services that are being offered,
20 consultative on matters of how to get the most effectual
21 administration within the limits that we talked about,
22 that is, trying to get the maximum of local control,
23 advisory in respect of almost any matter that had to do
24 with that nation-wide programme, where because of its
25 position the Federal Government could do the best job
26 in advising and in effecting this consultation, that
27 would make their advice the best, and, of course, again
28 this refers back I suppose to content, and the uniform
29 terms that are mentioned in the same sense. Now, here
30 Dr. Roth and Dr. Acker might care to comment, or anyone



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1 else for that matter. I can certainly see in a sense
2 that there would just be a host of matters where
3 consultation and advice is of the essence if a plan is
4 going to have the maximum benefit for all the persons
5 that are engaged in it.

6 DR. ROTH: Well, I think, sir, that
7 what is meant here, and certainly this arises out of our
8 experience in working with the Federal Department of
9 Health in Hospital Insurance, that the consultative and
10 advisory services are largely in the field of
11 administration, and this I don't think means, and I
12 cannot envisage really consultation in the sense that
13 we think of in the form of medical consultation,
14 consultation to patients, or referring a patient from
15 one doctor to another for medical opinion. I think it
16 is really consultative and advisory in the terms of
17 administration, in data-processing, data-collection,
18 analysis, and this sort of thing that is now going on
19 between the provinces and the Federal Government. It
20 still leaves much to be desired. I think we all recog-
21 nize this, but we are all, the provinces and the Federal
22 Government, are making a very sincere effort. On one
23 hand for us to provide basic data, and for the Federal
24 Government to provide quite complicated technical
25 advice on the analysis and interpretation of this data.

26 COMMISSIONER FIRESTONE: Mr. Minister,
27 in order to enable the Commission to offer some specific
28 recommendation on this point, would it be possible for
29 your Department, at a subsequent time, to let the
30 Commission know an outline of what those consultative



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1 and advisory services might be in specific categories,
2 and serving specific objectives, so that the Commission
3 when it considers what it can recommend to the Government,
4 has something specific to recommend, rather than just a
5 broad sort of service. Would that be possible to obtain
6 at a later date?

7 HON. MR. DAVIES: Certainly. One
8 point further however, that the nature of the framework
9 is going to some extent indicate the direction of your
10 directions in this consultative and advisory framework,
11 in these terms, if this is what is meant by specific we
12 will try and provide it.

13 COMMISSIONER FIRESTONE: Within the
14 framework as you have envisaged it, sir.

15 HON. MR. DAVIES: Yes.

16 COMMISSIONER FIRESTONE: Thank you
17 very much, Mr. Minister. I come to the next statement
18 in the same paragraph, where you comment on the financial
19 support you might be able to obtain from the Federal
20 Government, and the principle that should underlie such
21 contribution, and you say that such a plan must be
22 developed on the principle of equalization of provincial
23 ability to meet a share of the cost. Now, Mr. Minister,
24 would you consider a flat sixty per cent rate a
25 contribution to all provinces on the same flat percentage
26 rate following the principle of equalization of provincial
27 ability to pay?

28 HON. MR. DAVIES: We have said at
29 least sixty per cent here.

30 COMMISSIONER FIRESTONE: I appreciate



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1 that, Mr. Minister, but we are trying to establish what
2 kind of formula could be developed which would take into
3 account (a) a flat rate, and (b) the special circumstances
4 which you have in mind, Mr. Minister, that there are
5 some provinces that can finance a programme easier than
6 others because of their greater ability to pay their
7 share of the cost, and therefore, I presume, Mr. Minister,
8 we could ask you to spell out for us, not necessarily
9 here, but on further consideration, some sort of formula
10 which would take account of the point that you
11 really have in mind here, and that is equalization as
12 distinct from a flat percentage rate, which applies to
13 everybody indiscriminately, and without regard to their
14 ability to pay. This is a difficult question. Could
15 we leave it to you and your Department to come forward
16 at a subsequent time in writing with a formula which
17 would spell this out and take account of the points that
18 you really have in mind?

19 HON. MR. DAVIES: We would be very
20 glad to attempt it, Dr. Firestone. We might work out
21 some frame of recommendations that would be useful.

22 COMMISSIONER FIRESTONE: Well, (a)
23 that would be useful in developing some recommendations,
24 but also, that would be acceptable to your own Government.

25 HON. MR. DAVIES: Very good.

26 COMMISSIONER FIRESTONE: Thank you
27 very much, Mr. Minister, and we can leave it in your hands
28 to let us have it at your convenience?

29 HON. MR. DAVIES: Certainly.

30 COMMISSIONER FIRESTONE: Now, if I



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11 really have in mind here, and that is equalization as
12 distinct from a flat percentage rate, which applied to
13 everybody indiscriminately, and without regard to their
14 financial position, and we would be very glad to have
15 we leave it to you and your Department to come forward
16 at a subsequent time in writing with a formula which
17 would spell this out and take account of the points that
18 you really have in mind?

19 HON. MR. DAVIES: We would be very

20 glad to attempt it, Dr. Watson. We might work out
21 some frame of recommendations that would be useful.

22 COMMISSIONER WATSON: Well, (a)

23 that would be useful in developing some recommendations,
24 but also, that would be acceptable to your own Government
25 HON. MR. DAVIES: Very good.

26 very much, Mr. Minister, and we can leave it in your hand
27 to let us have it at your convenience?

28 HON. MR. DAVIES: Certainly.



1 may come to paragraph 91, on page 34, sir. You recommend
2 two new grant categories, dental care and home nursing
3 care. Would it be possible to ask you in your subsequent
4 written submission to give us further details as to what
5 these grants should entail, and how they would be used?

6 HON. MR. DAVIES: Yes, we can try
7 and work out something of that kind. I think we have
8 already made some suggestions on the question of home
9 nursing. We are endeavouring to get a pilot plan,
10 experimental plans, instituted. This may not be under
11 the aegis of the Government, that is, the direct aegis,
12 in any event, but would be experimental, and would cover
13 what we have in mind, so I think we already have some
14 information on this.

15 COMMISSIONER FIRESTONE: Thank you
16 very much. If you can base your recommendation on
17 experience, so much the better, and we would welcome that
18 Mr. Minister. I turn now to paragraph 93, in which you
19 recommend that hospital construction grants be doubled,
20 that the Federal contribution be increased from \$2,000.00
21 to \$4,000.00. Now, Mr. Minister, I take it that one of
22 the reasons you are recommending this doubling of the
23 grant, is that hospital construction costs have risen
24 significantly since this \$2,000.00 hospital construction
25 grant was instituted, is that correct, sir?

26 HON. MR. DAVIES: Yes, this is
27 certainly the germ of the whole thing, the costs have
28 gone up very sharply.

29 COMMISSIONER FIRESTONE: When was
30 that \$2,000.00 grant first instituted, sir?



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COMMISSIONER WILKINSON: Then why
that \$2,000.00 grant first instituted, sir?



1 HON. MR. DAVIES: I think Dr.
2 Matthews will know when the grant was first instituted.

3 DR. MATTHEWS: In 1955, I think it
4 was changed from \$1,000.00 to \$2,000.00.

5 THE CHAIRMAN: Yes, but the idea of
6 the grant came earlier than that.

7 COMMISSIONER FIRESTONE: Well now,
8 let us assume it was raised to \$2,000.00 in 1955. Is
9 your suggestion that hospital construction costs have
10 doubled between 1955 and 1962, justifying a doubling of
11 the Federal Hospital Construction Grant?

12 HON. MR. DAVIES: Now again I would
13 have to discover whether --- I think one thing we can be
14 sure of is that the provincial contribution has gone up
15 proportionately a great deal more than the Federal
16 contribution, and I think when Dr. Van Wart was question-
17 ing me I gave to him a table which showed the money that
18 the province had been contributing for hospital
19 construction, as against the sum formerly contributed,
20 and we say too on this basis that the province itself
21 was doing much more in the way of hospital construction
22 cost than the Federal Government was assisting as well
23 in the same escalating fashion.

24 COMMISSIONER FIRESTONE: I was wonder-
25 ing, Mr. Minister, whether the doubling of the Federal
26 Government Hospital Construction Grant will really solve
27 your problem, or whether you are really not searching
28 for a system which will allow for increasing costs in
29 the future, whether you can come forward with a proposal
30 that would increase the grant as costs went on beyond

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1 the doubling of the grant, because that will only
2 perhaps bring you up to a stage you consider reasonable
3 as of this point of time, or the point of time that the
4 Commission may make its recommendation to the Canadian
5 Government. Your problem is one of continuously changing
6 costs, and do we not need some sort of mechanism to take
7 this into account, otherwise the problem will recur a
8 few years from now.

9 HON. MR. DAVIES: Certainly the idea
10 is very appealing, but I want to point out that the sum
11 of \$1,000.00 or \$2,000.00 in grants originally is
12 probably an arbitrary figure. It does not necessarily
13 become the fair figure, so if we just take an escalation
14 from those figures, you do not again necessarily arrive
15 at a fair figure, but you ask whether from 1955 to 1962
16 costs have doubled. I rather doubt it, but there has
17 been a very substantial increase. A great part of our
18 hospital building programme too took place up to the
19 years 1955, because of the fact that our plan started
20 in 1947, so that we were not able to get the complete
21 benefit, perhaps in terms of the grants that had been
22 established, but what we are saying here is that we
23 have substantially aided and assisted the local hospitals
24 by a new grant structure, and all we are saying is that
25 it will assist both the Government and the municipalities
26 if we are able to get a higher grant structure, since
27 obviously there has been, if it is not half, at least
28 a pretty drastically upward movement of costs, and then,
29 of course, if it has not doubled since 1955, I think if
30 you take --- if I am not rash in saying that since 1948

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1 the cost of hospital construction has doubled, and that
2 in this time the province and municipalities have borne
3 a considerable measure of the costs.

4 COMMISSIONER FIRESTONE: I take it
5 from your proposal, Mr. Minister, that you would consider
6 a doubling to \$4,000.00 a fair level?

7 HON. MR. DAVIES: Yes, it is fair in
8 the light of the fact that the average costs in
9 Saskatchewan are in the order of \$13,000.00 to \$15,000.00
10 a bed, and we think in the nature of this fact that
11 doubling to \$4,000.00 is about right.

12 COMMISSIONER FIRESTONE: Well now,
13 having reached a level which your Government considers
14 to be fair, would you not also be interested to provide
15 for some mechanism to protect yourself against
16 subsequent increases in hospital construction costs, and
17 if so, would you be prepared to consider what an equit-
18 able formula would be for the future, beyond the doubling?
19 After all, we are supposed to make recommendations to
20 the Federal Government, not covering just the immediate
21 future, but a longer-term, and advice from your
22 Government would be helpful to us in our deliberations.

23 HON. MR. DAVIES: If we could
24 establish to begin with what a fair grant should be, and
25 Heaven only knows that word fair might be subject to a
26 lot of argument, but if you get an agreed-on figure that
27 is a fair figure for the provincial grant and the federal
28 grant, and you could work from there, it seems to me
29 that you could have something that would be pretty
30 reasonable, that is, if the costs go up ten per cent in

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1 two years, here is a ten per cent increase in the grant.
2 This kind of proposition sounds pretty good. I don't
3 know how it looks when you start looking at it in a
4 more detailed fashion, but I don't mind the principle.

5 COMMISSIONER FIRESTONE: Would it
6 be possible for your Department, Mr. Minister, to look
7 at it in a detailed fashion, and give us your advice
8 subsequently in writing?

9 HON. MR. DAVIES: We will do our
10 best, Doctor.

11 COMMISSIONER FIRESTONE: I come to
12 the subject of drugs and drug prices. Could you tell
13 the Commission how the Government of Saskatchewan and
14 the hospitals of Saskatchewan purchase drugs?

15 HON. MR. DAVIES: Here I think I
16 shall turn to the people on my left, so that they can
17 give you the best information.

18 DR. ROTH: Well, drugs purchased
19 by the Government itself for its own institutions, the
20 mental hospitals and so forth, these are purchased by
21 competitive bids. All of them, as a matter of fact,
22 these bids are made by the purchasing agency of the
23 Government, and not by the hospital or Health Department,
24 as are all other purchases of the Government of
25 Saskatchewan.

26 COMMISSIONER FIRESTONE: You have a
27 central purchasing programme for drugs?

28 DR. ROTH: For all things. This is
29 for drugs that are supplied to institutions over which
30 the Government has direct control. This does not involve



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1 the local hospitals. This involves the mental hospitals
2 and those few hospitals in north which the Government
3 operates directly, and the institutions operated for
4 chronic diseases by the Department of Health, and so on.

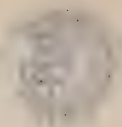
5 COMMISSIONER FIRESTONE: How do
6 the local hospitals purchase drugs?

7 DR. ROTH: A wide variety of
8 arrangements. Some purchase on tender, others do not.
9 We do not attempt to interfere with hospitals as to how
10 they purchase drugs. Although we interfere to the extent
11 that we say that in this Province there is a maximum
12 amount we will permit the hospitals to spend per patient
13 day for drugs, which we will meet under the Hospital
14 Insurance Programme.

15 COMMISSIONER FIRESTONE: Mr. Deputy-
16 Minister, have you found in the calling for tenders for
17 drugs, as far as the central purchasing is concerned,
18 there is frequently a wide range between the highest and
19 the lowest tender for like-drugs?

20 DR. ROTH: I couldn't answer that
21 question specifically, because this really is of no great
22 concern to us. We are concerned about the quality of
23 drugs that are purchased, and we are consulted by the
24 purchasing agency if there is any question of quality
25 involved. Otherwise they make the purchases. However,
26 for what it is worth, and this is merely an impression
27 and I only want it regarded as such, is that the bids
28 that are made to Government do not fluctuate very much
29 and are quite low on the whole.

30 COMMISSIONER FIRESTONE: Are you



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Minister, have you found in the calling for tenders for drugs, as far as the central purchasing is concerned, there is frequently a wide range between the highest and the lowest tender for like drugs?

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for what it is worth, and this is merely an impression and I only want it regarded as such, is that the bids that are made to Government do not fluctuate very much and are quite low on the whole.

COMMISSIONER TRENTON: Are you



1 suggesting that the difference between the highest and
2 lowest bidder is comparatively small as far as your
3 impression of Saskatchewan experience is concerned?

4 HON. MR. DAVIES: That is right.

5 COMMISSIONER FIRESTONE: Well, if
6 this is the case, you are in a very favourable position,
7 because we have just come from Winnipeg, where we were
8 told that the Manitoba Government's experience has shown
9 that there were differences of over four hundred per
10 cent between the highest and the lowest bidder for like-
11 type drugs. Now, if your experience is so much more
12 favourable, I would be curious to know why?

13 COMMISSIONER McCUTCHEON: Maybe
14 Saskatchewan gets all the high bids.

15 DR. ROTH: This is a long standing
16 arrangement in this province, and I think that we would
17 be able to procure for you, if this is of real interest
18 to you, comparative prices without identification. I
19 don't know that purchasing agency would want to identify
20 the people who bid, but I think it would be quite
21 possible to get ranges of selected drugs at various times,
22 and the ranges of the bids that were received.

23 COMMISSIONER FIRESTONE: This would
24 be very helpful, and if we may turn over the matter to
25 our own research staff, and if they could get in touch
26 with your Department, perhaps that type of information
27 could be made available to us. We would be interested
28 in comparing the like-type drugs as compared to the
29 price paid in Manitoba and Saskatchewan, and why one
30 province is paying perhaps a good deal more than other.

suggesting that the difference between the highest and

lowest bid was about 10 per cent.

That is right.

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1 I take it if we are to plan for a pre-paid drug plan
2 we would be interested not only in the one province,
3 but in Canada as a whole, to purchase at the lowest
4 possible price, and that leads me to another question,
5 as to why the Province of Saskatchewan has not taken
6 perhaps a somewhat more direct interest in the method of
7 drug purchasing by local hospitals, if we know that
8 competitive bidding is one manner in which drug prices
9 at the lowest possible level can be obtained?

10 HON. MR. DAVIES: I think, subject
11 to what Dr. Roth has to say, we feel that the bids we
12 have been receiving are, in relation to other jurisdic-
13 tions -- and this well might be discovered -- not high
14 but low, and the figures that we fix for the various
15 hospitals in the one hundred and fifty-four hospital
16 jurisdictions in the province have some recognition of
17 this. That is to say, their drug costs must of necessity
18 bear a relationship to the amount that we suggest is
19 the proper amount to be spent on drugs, and again unless
20 you take over the management of each one of the hospitals,
21 which we, of course, have no intention of doing, and
22 unless you ride herd on each single operation, it is
23 rather difficult to suggest arrangements where we could
24 in effect say, "You must buy this type of drug and it
25 must be from this manufacturer.", because in many cases
26 this manufacturer will predicate the particular charge
27 for the particular drug. I rather think on the whole
28 the prices that are being paid are not only competitive
29 but would be probably as low as in most hospital
30 jurisdictions -- perhaps lower -- and I think the prices



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1 our Government is paying for drugs would be certainly
2 lower. This is something, I admit, I am speculating on,
3 and it will be the subject of investigation by us for
4 the scrutiny of your Commission. Certainly, however,
5 you realize the difficulty of the province without
6 interfering too aversely with the hospital jurisdictions
7 or laying down an iron-clad rule that the purchases of
8 drugs have to be in a given way, and so forth.

9 COMMISSIONER FIRESTONE: Would you
10 agree, Mr. Minister, that by requiring hospitals to use
11 the tender system in purchasing drugs this would in no
12 way mean a centralization of drug purchases?

13 HON. MR. DAVIES: No, I think it
14 would be quite possible for each hospital to ask for
15 tenders; that there be a proviso of this kind. I think,
16 however, subject to correction, that some hospitals,
17 while they don't call for tenders generally, they use
18 invitational tenders where they might call a given number
19 of drug manufacturers who have been in the habit of
20 giving them some pretty good prices, and I think these
21 prices again compare favourably. I wondered about this
22 myself, whether we should not as a matter of policy say,
23 "You are required to tender", but I must point out many
24 of the hospitals say, "We are following this practice
25 by the invitational tender, and, as a matter of fact,
26 we prefer the relations we have had with this company."

27 COMMISSIONER FIRESTONE: In thinking
28 ahead to the possibility of a pre-paid drug plan, I
29 take it that such a tender system may become an essential
30 feature. If that is forward thinking, why not do



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feature. It that is forward thinking, why not do



1 something about it before a plan is introduced, so that
2 the experience can be gained and this system is in
3 operation as and when it is required?

4 HON. MR. DAVIES: I quite agree with
5 you, with the introduction of drugs as a benefit, it
6 would need to be considered by everyone in the picture;
7 some means by which we can get fair and equitable prices,
8 and I am thoroughly in accord with that, and I think
9 probably the tender basis is one of the ways it can be
10 accomplished. But, I don't think, with respect, it is
11 the only way.

12 COMMISSIONER FIRESTONE: On the
13 contrary, Mr. Minister, we would rely on your imagination
14 to have a number of possibilities of controlling drug
15 prices and keeping them as low as possible. I am sure
16 we can rely on you and your colleagues to think of them.

17 May I now turn to a last set of
18 questions which relate to a statement which is contained
19 in the brief of the Canadian Mental Health Association,
20 Saskatchewan Division, which will come before us
21 probably tomorrow, and I quote from page 10:

22 " The mentally ill in Saskatchewan
23 are second-class citizens.", and "the
24 Departments of Public Health have two sets
25 of standards for health care. One set of
26 standards (and these are very admirable)
27 they enforce on all general hospitals.
28 Another set of standards (much inferior)
29 they apply to their own mental hospitals."

30 Have you any comments to offer?



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Have you any comments to offer?



1 HON. MR. DAVIES: I think, Mr.
2 Chairman, that we would say this first of all, that in
3 the field of mental health services Saskatchewan has
4 been making, as I may have pointed out earlier in this
5 proceedings, a considerably greater effort than any other
6 province for many years. I want to give an example
7 here by comparing by provinces the per capita expendi-
8 tures on mental health excluding the out-patient clinics
9 and other community facilities. You will find
10 Saskatchewan's per capita expenditures have exceeded
11 every province for many years. In 1948 the per capita
12 operating expenditures in Saskatchewan were \$4.46
13 compared to \$2.80 in Ontario which was the second best
14 province, and \$2.53 for the country as a whole at that
15 time. In 1959 the per capita operating expenditures
16 of mental institutions in Saskatchewan were \$9.62; this
17 is followed by British Columbia at \$8.22, Alberta \$7.63,
18 Ontario \$7.26 and Manitoba \$5.93, with a national average
19 of \$7.19. I pointed out this morning, I think, the
20 difficulty and perhaps falacy of equating the charges
21 in mental hospitals with those of the general hospitals
22 where a broader and more extensive level of services
23 is obviously required, and I think this has to be
24 considered in this type of discussion. Also I think I
25 would concede that over a period of years our programme
26 in the Province of Saskatchewan has probably been
27 considerably ahead of the other provinces in the Dominion.
28 However, of late years these provinces have made a splurt;
29 they have caught up and probably they have moved somewhat
30 faster than our improvements in this province, still

Chairman, that we would say this first of all, that in the field of mental health services Saskatchewan has been making, as I may have pointed out earlier in this proceedings, a considerably greater effort than any other province for many years. I want to give an example here by comparing by provinces the per capita expenditures on mental health excluding the out-patient clinics and other community facilities. You will find every province for many years. In 1948 the per capita operating expenditures in Saskatchewan were \$4.46 compared to \$2.80 in Ontario which was the second best province, and \$2.53 for the country as a whole at that time. In 1950 the per capita operating expenditures of mental institutions in Saskatchewan were \$2.62; this is followed by British Columbia at \$2.12, Alberta \$1.53, Ontario \$1.26 and Manitoba \$1.02, with a national average of \$1.10. I pointed out this morning, I think, the difficulty and perhaps fallacy of equating the charges in mental hospitals with those of the general hospitals where a broader and more extensive level of services is obviously required, and I think this has to be considered in this type of discussion. Also I think I would concede that over a period of years our programme in the Province of Saskatchewan has probably been considerably ahead of the other provinces in the Dominion. However, of late years these provinces have made a slight, they have caught up and probably they have moved somewhat faster than our improvements in this province, still



1 remembering that the picture I have given you as of
2 1959 which are the latest available figures, does show
3 that we still have a margin of benefits. We do look to
4 some improvements in the province, and these improvements
5 would have by this time been generated except for
6 certain factors. We contemplate, as you know, the
7 building of a regional medical hospital in the community
8 of Yorkton. There have been several hundred thousand
9 dollars spent on the enlarging of the general hospital
10 facilities at Yorkton for the accommodation of the
11 cottage type buildings that are surrounding and will
12 form part of the services we offer for the mentally ill
13 patients. This has been perhaps unfortunately delayed.
14 I must point out that we had for two years something
15 that we didn't expect but which is not unprecedented in
16 this country -- a rather poor crop year. We look to
17 the predictions for an upswing this year, yet at the
18 same time there are certain economies we have felt it
19 necessary to exercise. I have great hopes -- and I
20 can't here speak definitely; the budget, of course, has
21 not been before the legislature -- but I have hopes
22 that something can be done about proceeding with the
23 building of this institution, and that this will be in
24 earnest the next step we would like to take, and
25 this again is part of this entire conception of mental
26 health care that I or some other member of the
27 Commission was touching on during this morning's sitting.
28 We are anxious this be so. Again, when you look for
29 this service, and the other health services, and we
30 think of one against another, the picture as shown in



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1 the one sector does not look so bad, and I think again
2 frankly we would like to move ahead. I hope we can,
3 and I still think the picture that is present in the
4 province is not at all one to be ashamed of.

5 COMMISSIONER FIRESTONE: Thank you,
6 Mr. Minister. My last question refers to a recommendation
7 of the Canadian Mental Health Association, Saskatchewan
8 Division, and I quote:

9 " ... an overall medical care plan,
10 must receive the same standards of care
11 whether they are mentally or physically ill.:

12 Do I take it, Mr. Minister, that you
13 are in agreement with this principle, in line with the
14 principle you outline in paragraph 6 on page 2 of your
15 brief when you state that you believe that every
16 Canadian has the right to a uniformly high quality of
17 health services, and does "uniformly high quality of
18 health services" cover both the physically and the ment-
19 ally ill?

20 HON. MR. DAVIES: We would like to
21 see the best quality of care for the physically disabled
22 and the best quality of care for the mentally disabled
23 provided.

24 COMMISSIONER FIRESTONE: Does the
25 word "uniformly" mean it would apply to both types?

26 HON. MR. DAVIES: Except that the one
27 point -- uniformity does not mean the same thing in terms
28 of treatment or cost. If you want to say this means
29 exactly the same expenditure of funds?

30 COMMISSIONER FIRESTONE: No, I didn't



Frankly we would like to move ahead. I hope we can,
and I still think the province ought to provide in this
province is not at all one to be ashamed of.

COMMISSIONER FIRESTONE: Thank you.

Mr. Minister. My last question refers to a recommendation
of the Canadian Mental Health Association, Saskatchewan
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see the best quality of care for the physically disabled
and the best quality of care for the mentally disabled
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word "uniformly" mean it would apply to both types?
HON. MR. DAVIES: Except that the one
point -- uniformity does not mean the same thing in terms
of treatment or cost. If you want to say this means



1 mean that. I just refer to your own definition of
2 "uniformly high quality" and I am leaving it to the
3 experts to determine what is high quality.

4 HON. MR. DAVIES: The answer to that
5 question is "yes".

6 COMMISSIONER FIRESTONE: Thank you
7 very much, Mr. Minister; you have been most patient and
8 helpful.

9 THE CHAIRMAN: Ladies and gentlemen,
10 there has been a reference to the brief of the Canadian
11 Mental Health Association, and so that it may be
12 formalized to that extent, it will be entered as Exhibit
13 79.

14
15 --- EXHIBIT NO. 79: Brief of Canadian
16 Mental Health Association
17 Saskatchewan Division.

18 THE CHAIRMAN: I think there has
19 been a pre-publication of the brief of the College of
20 Physicians and Surgeons before it was presented, and so
21 in some effort to rationalize that we will receive it
22 today as Exhibit 80.

23
24 --- EXHIBIT NO. 80: Brief of the College of
25 Physicians and Surgeons
26 of Saskatchewan.

27 THE CHAIRMAN: We will now adjourn
28 until 9.00 o'clock tomorrow morning, and I ask you, Mr.
29 Davies, if you will be able to return.

30 HON. MR. DAVIES: As a matter of fact,



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Davies

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there has been a reference to the brief of the Canadian
Mental Health Association, and so that it may be
formalized to that extent, it will be entered as Exhibit

Brief of Canadian
Mental Health Association

EXHIBIT NO. 70:

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been a pre-publication of the brief of the College of
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THE CHAIRMAN: We will now adjourn

until 9.00 o'clock tomorrow morning, and I ask you, Mr.
Davies, if you will be able to return.

HON. MR. DAVIES: As a matter of fact



1 sir, I had rather hoped that I would be able to return
2 to my own duties tomorrow. I shall certainly make an
3 effort to be here if that is what is desired. From the
4 agenda that I had looked at earlier this week, it seemed
5 to me that our hearing was not to be as protracted as
6 it has been. I don't object to this; all I am saying
7 is that I had no expectation it would go beyond today.

8 THE CHAIRMAN: I didn't either, Mr.
9 Davies; but it would be a matter of accommodation to the
10 Commission if you could be here at 9.00 o'clock tomorrow
11 morning for about half an hour.

12 HON. MR. DAVIES: This would help
13 us very much, if we know how long we will be.

14 THE CHAIRMAN: Thank you very much.

15
16 --- Adjournment.
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THE CHAIRMAN: Thank you very much.

